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DACA: Time to act
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The Hospitalist

VOLUME 21 No. 11 | NOVEMBER 2017

AN OFFICIAL PUBLICATION OF THE SOCIETY OF HOSPITAL MEDICINE

KEY CLINICAL QUESTION

Underlying peripheral arterial or venous disease in patients with lower extremity SSTIs

How can hospitalists best recognize and manage these challenging cases?

By Anjali A. Nigalaye, MD, and Eve R. Merrill, MD
Division of Hospital Medicine, Mount Sinai Beth Israel, New York

Clinical case

A 56-year-old woman with type 2 diabetes, morbid obesity, and hypertension presents with right lower extremity erythema, weeping, and exquisite tenderness associated with chills. She reports a 2-year history of chronic lower extremity swelling and cramps with a more recent development of scaling and two superficial ulcers on the lower third of her leg. For 1 month, she has noted significant pain circumferentially around the ankles with focal tautness and pallor of the skin. She has tried acetaminophen and oxycodone with little relief.

Over the past week, she noted foul smelling discharge from one of the superficial ulcers with redness extending up to the knee prompting presentation to the emergency department. She had a fever to 101.2° F, tachycardia to 105 beats per minute, and leukocytosis to 14.7. She is admitted to the hospitalist service for sepsis secondary to right lower extremity cellulitis.

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DNA Illustrations / Science Source

Reducing harm: When doing less is enough

Choosing Wisely shifts focus to implementation

By Suzanne Bopp

Launched in April 2012 – the same year an article in the Journal of the American Medical Association estimated the U.S. health care system was wasting between $600 billion and $1 trillion annually because of issues such as overtreatment – Choosing Wisely continues to change both conversations and practices across the medical field.[1]

In creating Choosing Wisely, the ABIM Foundation sought to establish a framework for physicians to think about managing resources and to talk to patients about which medical tests and procedures might be unnecessary – or even harmful.

"What we're trying to do is avoid harm," said Daniel Wolfson, executive vice president and chief operating officer of ABIM. "That harm can be clinical, physical, psychological, and financial. That's what we're trying to reduce."

Mr. Wolfson

Today, more than 75 medical specialties have their own "five things" lists: procedures that practitioners should question before ordering. Hospitalists have a total of 10 procedures – 5 for adults and 5 for pediatrics – and hospitalists play a pivotal role in Choosing Wisely's implementation, with crucial control over service lines. "Hospitalists are on the front line of patient care," said Moises Auron, MD, FAAP, FACP, SFHM, a hospitalist at the Cleveland Clinic. "We are actually the frontline workers in the hospital."

Choosing Wisely's successes

In terms of its initial goal – starting

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Q&A SHM MEMBER SPOTLIGHT

Lorraine Britting, ANP, SFHM

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HOSPITALIST MOVERS AND SHAKERS

By Matt Pesyna

Pediatric hospitalist **Patrick Conway, MD**, has been named president and chief executive officer of Blue Cross and Blue Shield of North Carolina. Dr. Conway will take over for the retiring Brad Wilson on Oct. 1.


Dr. Conway

Dr. Conway is currently the deputy administrator for Innovation and Quality, and the director of the Center for Medicare & Medicaid Innovation for the Centers for Medicare and Medicaid Services (CMS). Previously, he was chief medical officer at CMS, having served both the Obama and Trump administrations.

Dr. Conway received the high honor of being elected to the National Academy of Medicine in 2014, and he has been selected as a Master of Hospital Medicine by the Society of Hospital Medicine.

Hossam Hafez, MD, recently claimed the role of chief of Hospitalist Service with Health Quest Medical Practice (LaGrangeville, N.Y.). Dr. Hafez will be based out of Health Quest's Vassar Brothers Medical Center in Poughkeepsie, N.Y., coordinating care in that hospital and throughout the Health Quest system.

Dr. Hafez has served full-time hospitalist stints with MidMichigan Health's Physician Hospitalist Group, as well as with RiteMed Urgent Care. A native of Egypt, Dr. Hafez is fluent in both English and Arabic.

Caldwell UNC Healthcare (Lenoir, N.C.) has promoted **David Lowry, MD**, to chief medical officer as of Aug. 1, 2017.

Dr. Lowry, a longtime hospitalist and veteran in hospital medicine in general, will lead the building's hospitalist program, support the chief of staff, and provide direct patient care, as well. He will serve as physician adviser for Caldwell's Clinical Documentation, Utilization Review, Respiratory Care, and Rehabilitation departments.

Dr. Lowry boasts more than 25 years experience in hospital medicine and led in the creation of Caldwell's hospitalist program. Since joining Caldwell, he has held leadership positions including chief of medicine.

He received the hospital's Donald D. McNeill Jr. Award for Outstanding Physician Leadership in 2014, as voted by his peers.

Joahd Toure, MD, recently was hired by Adirondack Health (Saranac Lake, N.Y.) as its new chief medical officer. He started his new position in late June 2017.

Dr. Toure will oversee quality care for Adirondack Medical Center, as well as its subsidiaries, including four health centers, a women's health center, a nursing home, a dental practice, and more.


Dr. Toure

A Massachusetts native, Dr. Toure most recently worked as chief of hospitalist medicine with AdvantageCare Physicians in New York City. There, he helped manage care for patients in that system's 16 hospitals in the New York metro area. Previously, he was regional medical director for Essex Inpatient Physicians (Boxford, Mass.) and a staff hospitalist at South Shore Hospital (South Weymouth, Mass.).

Longtime employee **Emily Chapman, MD**, has been promoted to chief medical officer and vice president of medical affairs at Children's Minnesota Hospital (Minneapolis). The former vice CMO took on her new role on July 5, 2017.

A 10-year veteran at Children's Minnesota, Dr. Chapman will lead, direct, and oversee all clinical initiatives in the Children's system, focusing on improved performance, safety of patients, education, and research. She will be part of Children's strategy operation, as well.


Dr. Chapman

Previously, Dr. Chapman served Children's as its hospitalist program director, and as director of graduate medical education. She is an American Academy of Pediatrics Fellow.

Mark Sockell, MD, is the new chief medical officer at Meritage Medical Network in Novato, Calif. Meritage is a physician-run network that includes more than 700 board-certified physicians in both primary care and specialist fields. TH

BUSINESS MOVES

Hammond-Henry Hospital (Geneseo, Ill.) recently announced the creation of a hospitalist program, utilizing the facility's own emergency room physicians. Hammond-Henry will staff one emergency room doctor available for rounds outside of their ER work throughout the day.

Avera Queen of Peace Hospital (Mitchell, S.D.) started its own hospitalist program on Aug. 1, 2017, launching with the goal of improving patient experience within the building. Avera's hospitalists will be on site for 12 hours each day, assisting specialists and working with patients who do not have a local primary care physician.

The Hospitalist
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THE HOSPITALIST is the official newspaper of the Society of Hospital Medicine, reporting on issues and trends in hospital medicine. THE HOSPITALIST reaches more than 35,000 hospitalists, physician assistants, nurse practitioners, medical residents, and healthcare administrators interested in the practice and business of hospital medicine. Content for THE HOSPITALIST is provided by Frontline Medical Communications. Content for the Society Pages is provided by the Society of Hospital Medicine.

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Q&A

Inclusion valued by advanced practice providers

Lorraine Britting, ANP, SFHM, encourages nonlinear career development

By Felicia Steele

Editor's note: *Each month, the Society of Hospital Medicine puts the spotlight on some of our most active members who are making substantial contributions to hospital medicine. Log on to* www.hospitalmedicine.org/getinvolved *for more information on how you can lend your expertise to help SHM improve the care of hospitalized patients.*

This month, The Hospitalist spotlights Lorraine Britting, ANP, SFHM, clinical director of advanced practice in cardiology medicine at Beth Israel Deaconess Medical Center, Boston. Ms. Britting has been an SHM member for over 10 years, has served on various SHM committees, and was one of the first nurse practitioners to earn the Senior Fellow in Hospital Medicine designation.

How did you become a hospital medicine nurse practitioner, and when did you join SHM?

I was a nurse working in a coronary care unit and medical intensive care unit for 19 years when I graduated from a master's program as a nurse practitioner (NP) in adult care. I thought I was going to work in the outpatient side after graduation, but my experience was much more suited to hospital medicine.

My first job in 2004 was as a hospitalist in a very small community hospital affiliated with Beth Israel Deaconess Medical Center. I was the first NP to work as an inpatient provider there, which was challenging, but I had the opportunity to wear many hats and be involved with numerous quality initiatives that helped me grow as a provider and a leader. I was working as the clinical manager of three hospitalist programs under the director by the time I left. I now work in inpatient cardiology and am the director of advanced practice providers (APPs) for cardiology medicine. I joined SHM in 2005 when it was a small but rapidly growing society, and I started work on the NP/PA Committee. I was also involved in the Hospital Quality and Patient Safety Committee for 6 years and worked as a peer reviewer for the *Journal of Hospital Medicine*.

Describe your role on the Membership Committee. What is the committee currently working on?

I am finishing my 3rd year on the committee. In the last few months, we have been focusing on member engagement. We have collected information on why members choose to join SHM and what deters potential members from joining SHM, and we are developing strategies to build and retain our membership. The Membership Committee also reviews Fellows applications and discusses modifications of requirements each year.

As an NP, I have unique insight into motivations for why other APPs would join SHM and which membership benefits are most valuable. I find that many APPs join SHM because they feel that SHM treats them as equals, not junior members, as in some other physician organizations.

What does the Senior Fellow in Hospital Medicine designation mean to you?

> As an NP, I have unique insight into motivations for why other APPs would join SHM and which membership benefits are most valuable.
>
> —*Lorraine Britting, ANP, SFHM*

I am grateful that SHM allows all members to be a part of the Fellows program, and I was honored to be one of the first NPs to become a Senior Fellow. Many medical societies allow APPs to join but do not offer the opportunity to become Fellows.

The Senior Fellowship application was a rigorous process and required experience in multiple areas, including quality projects, hospital committees, SHM Annual Conference attendance, and other clinical and nonclinical work that advances the profession.

As a nurse practitioner, which SHM resources do you find most valuable?

As a specialist NP, it's easy for me to be current in cardiology but harder to keep current in general medicine. I find the clinical information very helpful to keep me up to date on hospital medicine. The *Journal of Hospital Medicine* and *The Hospitalist* are must reads, and the Annual Conference is, of course, very informative. I also enjoy the conversations on the Hospital Medicine Exchange and feel that the Choosing Wisely campaign is an excellent contribution to the goal of cost containment in everyday practice.

One of the best features of SHM is that I can meet other clinicians from around the country and around the world who have innovations or novel ideas that I can bring back to my institution.

What advice do you have for nurse practitioners as their role in hospital medicine continues to evolve?

I say to my staff that they should always say yes. Yes to continuing education, yes to opportunities for growth and advancement, yes to promotions, yes to research, etc. Careers develop in nonlinear ways, and you have to follow the opportunities as they come. TH

Ms. Steele is the marketing communications specialist at the Society of Hospital Medicine.

NEWS & NOTES

Get the latest news about upcoming events, new programs, and SHM initiatives

By Brett Radler

Recognizing American Diabetes Month, COPD Month, and CDC's Get Smart Week with QI Solutions

➤ There's no better time than during **American Diabetes Month** to learn more about SHM's Glycemic Control programs. Find out how your institution can submit point-of-care data to SHM's Data Center, generate monthly reports, and be included in the national glucometrics benchmark report. Be one of the 100-plus hospitals nationwide that are supported by SHM's respected Glycemic Control Programs. Contact Sara Platt for a free demo at splatt@hospitalmedicine.org or by phone at 267-702-2672. For additional information, visit hospitalmedicine.org/gc.

➤ November marks **Chronic Obstructive Pulmonary Disease (COPD) Month**, and it is critical that hospitals begin to direct QI resources to improving care for COPD patients. SHM developed a free guide to help you make changes to COPD care at both the individual patient and the institutional levels. Visit hospitalmedicine.org/COPD to download the guide.

➤ And, in conjunction with the **Centers for Disease Control & Prevention's Get Smart Week**, SHM is committed to promoting improved antibiotic prescribing behaviors among U.S. hospitalists. Through the Fight the Resistance campaign, SHM has developed many antimicrobial stewardship resources, including an implementation guide, four educational modules, and posters to hang in your hospital. Learn more at hospitalmedicine.org/abx.

Present your abstract in front of a national audience at HM18

➤ SHM is accepting submissions for the Research, Innovations, and Clinical Vignettes (RIV) Competition at Hospital Medicine 2018 (HM18). Based on past experience, the RIV Competition is likely to be one of the most popular events at HM18.

The competition features more than 1,700 applicants vying for approximately 900 poster spots.

Plenary and oral sessions are chosen from the pool of abstracts prior to the conference, and authors are invited to present on site at HM18 in front of a national audience.

Many of the cutting-edge abstracts that are first presented at SHM's RIV sessions go on to be published in highly respected

medical journals. The competition also includes a special Trainee Award category for resident and student authors.

SHM is excited to launch the Resident Travel Grant for 10 residents to receive funding to help cover the costs of travel and accommodations to attend SHM's annual conference.

See full details on how to apply and the selection process at shmannualconference.org/riv.

The submission deadline is Sunday, Dec. 3, 2017.

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Swarm and suspicion leadership

Articulating a mission that others can rally around and follow

By Leonard J. Marcus, PhD

During your career, you serve as staff member and leader to many different professional groups. Some are collaborative, collegial, and supportive. Others are competitive, antagonistic, or even combative. What are the benefits and downsides of each of these cultures and what can you do, as a hospitalist leader, to influence the character of your workplace?

There are arguments favoring each option. For people who prefer a warm, encouraging workplace environment, there is the pleasure and satisfaction that comes with the camaraderie of a friendly atmosphere. It boosts morale, reduces turnover, and assists in problem solving. Others argue that a "kumbaya" tone encourages sloppy practices and wastes time in social interaction and on decisions that favor personal factors over clinical precision. The competitive tone brings out the best in people, it is countered, and encourages excellence.

The field of "game theory" provides insights into the distinction. The first questions to ask are "What is the game you are playing?" and then "Who is the competition?" In a "winner-takes-all" scenario, such as a sporting event, each team seeks strategic advantage over the other team. In baseball terms, the winner gets more points when at bat and denies more points when on the field. However, when competing as a team, winning together requires collaboration to build strategy, execute plays, and reach victory. You compete against the other team and collaborate within your own team.

Scientists who study negotiation strategies and conflict resolution find that collaborative groups spend less time countering one another and, instead, investing that same effort into building constructive outcomes, a force multiplier.

In the winner-takes-all model, the baseball team that gets "outs," makes plays, and advances team members to home plate wins. If there is contest within the team, players invest that same effort into seeking their own gain at the expense of others. Benefits derived from shared effort are shunned in favor of benefits accrued to one player over the other. It is a distinction between "I won" versus "We won."

Hospital medicine is not a win/lose sport, yet over the years, hospitalists have shared with me that their institution or group at times feels like a competitive field with winners and losers. If this distinction is placed on a continuum, what factors encourage a more collaborative environment and what factors do the opposite, toward the adversarial side of the continuum? It makes a substantive difference in the interactions and accomplishments that a group achieves.

My colleagues and I at Harvard study leaders in times of crisis. A crisis makes apparent what is often more subtle during routine times. Our study of leaders in the wake of the Boston Marathon bombings was among our most revealing.

During most crises, an operational leader is designated to oversee the whole of the response. This is an individual with organizational authority and subject-matter expertise appropriate to the situation at hand. In Boston, however, there were so many different jurisdictions – federal, state, and local – and so many different agencies, that no one leader stood above the others. They worked in a remarkably collaborative fashion. While the bombings themselves were tragic, the response itself was a success: All who survived the initial blasts lived, a function of remarkable emergency care, distribution to hospitals, and good medical care. The perpetrators were caught in 102 hours, and "Boston Strong" reflected a genuine city resilience.

These leaders worked together in ways that we had rarely seen before. What we discovered was a phenomenon we call "swarm leadership," inspired by the ways ants, bees, and termites engage in collective work and decision making. These creatures have clear lines of communication and structures for judgment calls, often about food sources, nesting locations, and threats.

There are five principles of swarm leadership:

- **Unity of mission** – In Boston, that was to "save lives," and it motivated and activated the whole of the response.
- **Generosity of spirit and action** – Across the community, people were eager to assist in the response.
- **Everyone stayed in their own lanes of responsibility and helped others succeed in theirs** – There were law enforcement, medical, and resilience activities and the theme across the leaders was "how can I help make you a success?"
- **No ego and no blame** – There was a level of emotional intelligence and maturity among the leaders.
- **A foundation of trusting relations** – These leaders had known one another for years and, though the decisions were tough, they were confident in the motives and actions of the others.

While the discovery emerged from our crisis research, the findings equally apply to other, more routine work and interactions. Conduct your own assessment. Have you worked in groups in which these principles of swarm leadership characterized the experience? People were focused on a shared mission: They were available to assist one another; accomplished their work in ways that were respectful and supportive of their different responsibilities; did not claim undue credit or swipe at each another; and knew one another well enough to trust the others' actions and motives.

The flip side of this continuum of collaboration and competition we term "suspicion leadership." This is characterized by selfish ambitions; narcissistic actions; grabs for authority and resources; credit taking for the good and accusations for the bad; and an environment of mistrust and back stabbing.

Leaders influence the tone and tenor of their own group's interactions as well as interactions among different working groups. As role models, if they articulate and demonstrate a mission that others can rally around, they forge that critical unity of mission. By contrast, suspicion leaders make it clear that "it is all about me and my priorities." There is much work to be done, and swarm leaders ensure that people have the resources, autonomy, and support necessary to get the job done. On the other end, the work environment is burdened by the uncertainties about who does what and who is responsible. Swarm leaders are focused on "we" and suspicion leaders are caught up on "me." There is no trust when people are suspicious of one another. Much can be accomplished when people believe in themselves, their colleagues, and the reasons that bring them together.

As a hospitalist leader, you influence where on this continuum your group will lie. It is your choice to be a role model for the principles of swarm, encouraging the same among others. When those principles become the beacons by which you work and relate, you will find an environment that inspires people to be and to do their best.

In the next column, how to build trust within your teams. TH

Dr. Marcus is director, Program on Health Care Negotiation and Conflict Resolution, at the Harvard T.H. Chan School of Public Health in Boston.

NEWS & NOTES

CONTINUED FROM PAGE 7

Distinguish yourself as a Class of 2018 Fellow

➤ SHM's Fellows designation is a prestigious way to differentiate yourself in the rapidly growing profession of hospital medicine. There are currently over 2,000 hospitalists who have earned the Fellow in Hospital Medicine (FHM) or Senior Fellow in Hospital Medicine (SFHM) designation by demonstrating the core values of leadership, teamwork, and quality improvement.

Apply now and learn how you can join this prestigious group of hospitalists at hospitalmedicine.org/fellows. **Applications officially close on Nov. 30, 2017**.

The hospital observation care problem

➤ Hospitalists provide the majority of observation care to Medicare beneficiaries and are often the primary points of contact for patients as they navigate the impact of inpatient and observation care determinations during and after their hospitalizations.

In 2017, SHM re-surveyed members to understand the state of hospital observation care after several legislative and regulatory changes. Read the white paper to get perspectives and solutions from SHM at hospitalmedicine.org/advocacy.

Introducing 'Ultrasonography: Essentials in Critical Care'

➤ Brought to you by SHM and CHEST®, the Ultrasonography: Essentials in Critical Care course will be held Dec. 1-3, 2017, at the CHEST Innovation, Simulation, and Training Center in Glenview, Ill.

Enhance your point-of-care ultrasonography skills through hands-on training by experts in the field. Discover key elements of critical care ultrasonography and practice image acquisition with human models using high-quality ultrasound machines in this intensive 3-day course. Participants will earn 20.50 *AMA PRA Category 1 Credits*™ and MOC points.

Learn more and register at livelearning.chestnet.org/ultrasonography.

Building a better SHM

➤ Next month, SHM is excited to debut a more customized experience for members, beginning with the launch of a new, mobile-responsive website, association management system and HMX platform. Learn what this means for you at hospitalmedicine.org/betterSHM.

Mr. Radler is marketing communications manager at the Society of Hospital Medicine.

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SNEAK PEEK

Journal of Hospital Medicine

Sustainability in the AAP Bronchiolitis Quality Improvement Project

By Kristin A. Shadman, MD; Shawn L. Ralston, MD, MS; Matthew D. Garber, MD; Jens Eickhoff, PhD; Grant M. Mussman, MD; Susan C. Walley, MD; Elizabeth Rice-Conboy, MS; Ryan J. Coller, MD, MPH

BACKGROUND AND OBJECTIVES: Adherence to American Academy of Pediatrics (AAP) bronchiolitis clinical practice guideline recommendations improved significantly through the AAP's multi-institutional collaborative the Bronchiolitis Quality Improvement Project (BQIP). We assessed sustainability of improvements at participating institutions for 1 year following completion of the collaborative.

METHODS: Twenty-one multidisciplinary hospital-based teams provided monthly data for key inpatient bronchiolitis measures during baseline and intervention bronchiolitis seasons. Nine sites provided data in the season following completion of the collaborative. Encounters included children younger than 24 months who were hospitalized for bronchiolitis without comorbid chronic illness, prematurity, or intensive care. Changes between baseline-, intervention-, and sustainability-season data were assessed using generalized linear mixed-effects models with site-specific random effects. Differences between hospital characteristics, baseline performance, and initial improvement among sites that did and did not participate in the sustainability season were compared.

RESULTS: A total of 2,275 discharges were reviewed, comprising 995 baseline-, 877 intervention-, and 403 sustainability-season encounters. Improvements in all key bronchiolitis quality measures achieved during the intervention season were maintained during the sustainability season, and orders for intermittent pulse oximetry increased from 40.6% (95% confidence interval, 22.8-61.1) to 79.2% (95% CI, 58.0-91.3). Sites that did and did not participate in the sustainability season had similar characteristics.

DISCUSSION: BQIP participating sites maintained improvements in key bronchiolitis quality measures for 1 year following the project's completion. This approach, which provided an evidence-based best-practice toolkit while building the quality-improvement capacity of local interdisciplinary teams, may support performance gains that persist beyond the active phase of the collaborative. TH

ALSO IN JHM THIS MONTH

The effect of an inpatient smoking cessation treatment program on hospital readmissions and length of stay

AUTHORS: Eline M. van den Broek-Altenburg, MS, MA; Adam J. Atherly, PhD

Treatment trends and outcomes in healthcare-associated pneumonia

AUTHORS: Sarah Haessler, MD; Tara Lagu, MD, MPH; Peter K. Lindenauer, MD, MSc; Daniel J. Skiest, MD; Aruna Priya, MA, MSc; Penelope S. Pekow, PhD; Marya D. Zilberberg, MD, MPH; Thomas L. Higgins, MD, MBA; Michael B. Rothberg, MD, MPH

What's the purpose of rounds? A qualitative study examining the perceptions of faculty and students

AUTHORS: Oliver Hulland; Jeanne Farnan, MD, MHPE; Raphael Rabinowitz; Lisa Kearns, MD, MS; Michele Long, MD; Bradley Monash, MD; Priti Bhansali, MD; H. Barrett Fromme, MD, MHPE

Association between anemia and fatigue in hospitalized patients: does the measure of anemia matter?

AUTHORS: Micah T. Prochaska, MD, MS; Richard Newcomb, BA; Graham Block, BA; Brian Park, BA; David O. Meltzer MD, PhD

Helping seniors plan for posthospital discharge needs before a hospitalization occurs: Results from the randomized control trial of planyourlifespan.org

AUTHORS: Lee A. Lindquist, MD, MPH, MBA; Vanessa Ramirez-Zohfeld, MPH; Priya D. Sunkara, MA; Chris Forcucci, RN, BSN; Dianne S. Campbell, BS; Phyllis Mitzen, MA; Jody D. Ciolino, PhD; Gayle Kricke, MSW; Anne Seltzer, LSW; Ana V. Ramirez, BA; Kenzie A. Cameron, PhD, MPH

SNEAK PEEK

The Hospital Leader blog

Less job security, fewer employer-paid benefits than in previous generations

By Leslie Flores, MHA, SFHM

What we expect and what we get from work

Are American workers becoming happier with less? An interesting article in the Wall Street Journal reported on the findings of a recent survey of U.S. workers by the Conference Board, a research organization. Although the survey wasn't specific to health care, much less to hospitalists, I see some parallels that might cause many of us to stop and think more carefully about what we expect from our work.

The Conference Board's findings highlight how American workers' employment relationships are evolving and how that is affecting what Americans think of as a "good" job. The biggest shift has come in the nature of the implied compact between workers and their employers; unlike a generation or two ago, U.S. workers no longer expect to receive generous benefits and lifelong employment in exchange for hard work and loyalty. In fact, I suspect many younger workers today would face the prospect of lifelong employment with a single company with distaste, if not outright horror.

American workers today tend to have less job security and fewer employer-paid benefits than they did in previous generations. A companion graphic in the WSJ reported that, while in 1973 only 6% of Americans said they worked too many hours and 7% said they had trouble completing their work in the time allotted, by 2016 26% said they often worked more than 48 hours a week and half said they work during their free time at least periodically. Two-thirds of Americans now say they need to spend at least half of their day working at high speeds or meeting tight deadlines.

Yet, despite these trends, the Conference Board found that, overall, U.S. workers are more satisfied with their jobs than they have been in the past. The WSJ article posits that workers are happier at work because they have adjusted to lower expectations of the employer-employee relationship. In addition, workers have more flexibility today to change jobs or companies to find the right fit or pursue advancement, and often have more influence over when, where, and how they do their jobs than ever before. Many are working as temps or independent contractors, or in similar "contingent" arrangements. Finally, more employers are offering a wider array of tools to aid with work-life balance, such as paid medical and family leave.

So what does all this have to do with hospitalists? TH

Read the full post at hospitalleader.org.

Rawpixel/Thinkstock

ALSO ON 'THE HOSPITAL LEADER' BLOG

POST: 95% of inpatient providers would get an F on this exam by Brad Flansbaum, DO, MPH, MHM

POST: When it comes to health care violence, silence isn't an option by Danielle B. Scheurer, MD, SFHM, MSCR

POST: How do we keep our providers safe? by Tracy Cardin, ACNP-BC, SFHM

POST: We have a voice. It's time we use it #DoctorsSpeakOut by Vineet Arora, MD, MAPP, MHM

Dabigatran, rivaroxaban linked to slight increase in GI bleeding risk

By Amy Karon
Frontline Medical News

FROM CLINICAL GASTROENTEROLOGY AND HEPATOLOGY

Compared with conventional anticoagulants, both dabigatran and rivaroxaban conferred small but statistically significant increases in the risk of major gastrointestinal bleeding in a systematic review and meta-analysis of randomized trials reported in the November issue of Clinical Gastroenterology and Hepatology (doi: 10.1016/j.cgh.2017.04.031).

But other novel oral anticoagulants (NOACs) showed no such effect compared with warfarin, aspirin, or placebo, reported Corey S. Miller, MD, of McGill University, Montreal, and his associates. "The potentially increased risk of GI bleeding associated with dabigatran and rivaroxaban observed in some of our subgroup analyses merits further consideration," they wrote.

The NOACs (also known as non–vitamin K antagonist oral anticoagulants) help prevent stroke in patients with atrial fibrillation and prevent and treat venous thromboembolism. However, large AF trials have linked all except apixaban to an increased risk of major GI bleeding compared with warfarin. Dabigatran currently is the only NOAC with an approved reversal agent, "making the question of GI bleeding risk even more consequential," the authors wrote.

They searched the MEDLINE, EMBASE, Cochrane, and ISI Web of Knowledge databases for reports of randomized trials of NOACs for approved indications published between 1980 and January 2016, which identified 43 trials of 166,289 patients. Most used warfarin as the comparator, but one study compared apixaban with aspirin and six studies compared apixaban, rivaroxaban, or dabigatran with placebo. Fifteen trials failed to specify bleeding sources and therefore could not be evaluated for the primary endpoint, the reviewers noted.

In the remaining 28 trials, 1.5% of NOAC recipients developed major GI bleeding, compared with 1.3% of recipients of conventional anticoagulants (odds ratio, 0.98; 95% confidence interval, 0.80-1.21). Five trials of dabigatran showed a 2% risk of major GI bleeding, compared with 1.4% with conventional anticoagulation, a slight but significant increase (OR, 1.27; 95% CI, 1.04-1.55). Eight trials of rivaroxaban showed a similar trend (bleeding risk, 1.7% vs. 1.3%; OR, 1.40; 95% CI, 1.15-1.70). In contrast, subgroup analyses of apixaban and edoxaban found no difference in risk of major GI bleeding versus conventional treatment.

Subgroup analyses by region found no differences except in Asia, where NOACs were associated with a significantly lower odds of major GI bleeding (0.5% and 1.2%, respectively; OR, 0.45; 95% CI, 0.22-0.91).

Most studies did not report minor or nonsevere bleeds or specify bleeding location within the GI tract, the reviewers noted. Given those caveats, NOACs and conventional anticoagulants conferred similar risks of clinically relevant nonmajor bleeding (0.6% and 0.6%, respectively), upper GI bleeding (1.5% and 1.6%), and lower GI bleeding (1.0% and 1.0%).

A post-hoc analysis using a random-effects model found no significant difference in risk of major GI bleeding between either rivaroxaban or dabigatran and conventional therapy, the reviewers said. In addition, the increased risk of bleeding with dabigatran was confined to the RELY and ROCKET trials of AF, both of which exposed patients to longer treatment periods. Dabigatran is coated with tartaric acid, which might have a "direct caustic effect on the intestinal lumen," they wrote. Also, NOACs are incompletely absorbed across the GI mucosa and therefore have some anticoagulant activity in the GI lumen, unlike warfarin or parenteral anticoagulants.

The reviewers disclosed no funding sources. Dr. Miller and another author reported having no conflicts of interest. One author received research grants and speaker honoraria from Boehringer Ingelheim Canada, Bayer Canada, Daiichi Sankyo, Bristol-Myers Squibb, and Pfizer Canada; another author disclosed serving as a consultant to Pendopharm, Boston Scientific, and Cook. TH

Q&A

Emphasizing an entrepreneurial spirit: Raman Palabindala, MD, SFHM

Dr. Palabindala joins *The Hospitalist* Editorial Advisory Board

By Eli Zimmerman

Venkatraraman "Raman" Palabindala, MD, FACP, SFHM, was destined to be a doctor since his first breath. Born in India, his father decided Dr. Palabindala would take the mantle as the doctor of the family, while his siblings took to other professions like engineering.

Eager to be in the thick of things, Dr. Palabindala has voraciously pursued leadership positions, leading to his current role as chief of the Division of Hospital Medicine at the University of Mississippi Medical Center, Jackson.

Over the course of his career, Dr. Palabindala has become engrossed with both the medical and business sides of medicine, hoping to break down some of the stigmas that each hold for the other. In India, Dr. Palabindala used writing to help educate rural populations on safe medical practices.

Dr. Palabindala is enthusiastic about his role as one of the eight new members of *The Hospitalist* editorial advisory board, and took time to tell us more about himself in a recent interview.

Q: How did you get into medicine?
A: It's all because of my dad's motivation. My father believed in education, so when I was born, he said, "He's going to be a doctor," and as I grew up, I just worked toward being a physician and nothing else. I didn't even have an option of choosing anything else. My dad said that I would be a doctor, and I am a doctor. I feel like that was the best thing that happened to me, though; it worked out well.

Q: How and when did you decide to go into hospital medicine?
A: After I came to the U.S., I joined residency in internal medicine at GBMC – that's Greater Baltimore Medical Center – it's affiliated with Johns Hopkins. I always wanted to be an internist, but my experiences in the clinic world were not so great. But I really enjoyed inpatient medicine, so in my 3rd year, when I was doing my chief residency year, I did get opportunities to join a fellowship, but I decided just to be a hospitalist at that time.

Q: What do you find to be rewarding about hospital medicine?
A: Everything. Transforming health care – I think we do that very efficiently, in terms of influencing policy, patient safety, patient-centered medical care, quality, and education. My first couple of years as a hospitalist, I was not especially excited about resident education, but later I became director and I enjoyed motivating the young physicians to learn the business aspects of medicine, quality metrics, and patient safety. When I was a resident, we were never told about all these things, and we were not trained by hospitalists.

Q: What is one of the biggest challenges in hospital medicine?
A: I think talking about the business aspect of medicine, because it is like a taboo. We don't really want to talk about whether the patient is covered or not covered by insurance, how much we are billing, and why we must discuss business issues while we are trying to focus on patient care, but these things are going to indirectly affect patient care, too. If you didn't note the patient status accurately, they are going to get an inappropriate bill.

Q: What's the best advice you have received that you try to pass on to your students?
A: Do the rounds at the bedside. We have the tendency of doing everything outside and then going in the room and just telling the patient what we are going to do. Instead, I encourage everyone to be at the bedside. Even without students, I go and sit at the bedside and then review the data in terms the patient can understand, and then explain the care plan, so they actually feel like we are at the bedside for a longer time. We are with the patient for at least 10-15 minutes, but at the same time, we are getting things done. I encourage my students and residents to do this.

Q: What is the worst advice you've received?
A: I don't know if this is the "worst" advice, but in my second year, I was trying to take some leadership positions and was told I should wait, that leadership skills come with experience. I do think that's a bad piece of advice. It's all about learning how hard you work and then how fast you learn, and then how fast you implement. People who work, learn, and implement quickly can make a difference.

Q: Outside of patient care, what other career interests do you have?
A: I'm interested in smart clinics, and I actually have a patent for smart clinic chains. I'm a big fan of primary care, because, like hospitalists revolutionized inpatient care, I think we can revolutionize the outpatient care experience as well. I don't think we are being very efficient with outpatient care.

But if I was not practicing medicine, I probably would be a chef. I like to cook, and I would open up my own restaurant if I was not doing this.

Q: Where do you see yourself in 10 years?
A: I want to be a consultant, evaluating hospitalist programs and guiding programs to grow and be more efficient. That, I think, would be the primary job that I would like to be doing, along with giving lectures and teaching about patient safety and quality, and educating younger physicians about the business of medicine.

University of Mississippi Medical Center

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—*Venkatraraman "Raman" Palabindala, MD, SFHM*

Q: What experience with SHM has made the most lasting impact on you?
A: I would say the best impression was from the Academic Hospitalist Academy meeting I attended in Denver. I think that was helpful, because it was like a boot camp where you have only a limited number of attendees with a dedicated mentor. That was amazing, and I learned a lot. It helped me in redesigning my approach to where I would like to be both short- and long-term. I implemented at least 50% of what I learned at that meeting.

Q: What's the best book that you've read recently and why was it the best?
A: *Being Mortal* by Atul Gawande. It's a really beautiful book. TH

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Medical malpractice and the hospitalist: Reasons for optimism

Risk for hospitalists of facing a claim is relatively low

Dr. Schaffer is an attending physician in the Hospital Medicine Unit at Brigham and Women's Hospital, an instructor at Harvard Medical School, and a senior clinical analytics specialist at CRICO/Risk Management Foundation of the Harvard Medical Institutions, all in Boston. Dr. Kachalia is an attending physician in the Hospital Medicine Unit at Brigham and Women's Hospital, an associate professor at Harvard Medical School, and the chief quality officer at Brigham and Women's Hospital.

Fear of malpractice litigation weighs on many physicians, including hospitalists. Specific concerns that physicians have about facing a malpractice claim include stigmatization, loss of confidence in one's own clinical skills, and a possible personal financial toll if an award exceeds the limit of one's malpractice insurance.

Physician worries about malpractice are increasingly being raised during discussions of burnout, with a recent National Academy of Medicine discussion paper listing malpractice concerns as a possible factor that could contribute to physician burnout.[1]

In addition to physician concerns about malpractice-related stigma, payment of a malpractice claim triggers reporting requirements. Among the organizations to which paid malpractice claims must be reported is the National Practitioner Data Bank, which is a government-run database of all malpractice payments made on behalf of individual physicians that can be queried by health care organizations as part of the credentialing process. Although the information in the National Practitioner Data Bank is not accessible to patients, a number of states – 17 in one published tally[2] – maintain websites providing publicly available information on individual physicians' malpractice history.

Malpractice fears also influence physician behavior generally, leading to defensive medicine, though the actual costs of defensive medicine are debated. A national survey of physicians by Bishop and colleagues found that 91% felt that physicians order more tests and procedures than patients require in order to try to avoid malpractice claims.[3] A survey of 1,020 hospitalists asked what testing they would undertake when provided clinical vignettes involving preoperative evaluation and syncope.[4] Overuse of testing was common among hospitalists, and most hospitalists who overused testing specified that a desire to reassure either themselves or the patient or patient's family was the reason for ordering the unnecessary testing.

The extent to which this overuse was driven by liability fears specifically is not clear. Overuse of testing was less common among physicians associated with Veterans Affairs Hospitals, who generally are not subject to personal medical malpractice liability. But a history of a prior malpractice claim was not associated with significantly greater overuse in the survey.

Hospitalists' concerns about medical liability notwithstanding, data on the absolute malpractice risk of hospitalists and current trends in medical liability are both encouraging. An important source of our understanding about the national medical malpractice landscape is CRICO Strategies National Comparative Benchmarking System (CBS), which includes the malpractice experience from multiple insurers and represents 400 hospitals and 165,000 physicians. A December 2014 analysis of cases involving hospitalists from the CBS database showed that the malpractice claims rate for hospitalists was lower than those for other comparable groups of physicians.[5] Hospitalists (in internal medicine) had a claims rate of 0.52 claims per 100 physician coverage–years, which was significantly lower than the claims rate for nonhospitalist internal medicine physicians (with a rate of 1.91 claims per 100 physician coverage–years) and for emergency medicine physicians (with a rate of 3.50 claims per 100 physician coverage–years).

The most common types of malpractice allegations made against hospitalists were related to medical treatment, diagnosis, and medications. Medication-related allegations made up almost 10% of claims against hospitalists, and a recent CRICO Benchmarking Report on medication-related malpractice claims found that the most common classes of medications involved in claims against hospitalists were anticoagulants, analgesics, and antibiotics.[6] Payment was made in about one-third of hospitalist cases, which is similar to other specialties. Among hospitalist cases in which a payment was made, the mean payment was $384,617, which is comparable to other inpatient paid claims, though significantly higher than the average payment on outpatient claims.

A remarkable national trend in medical malpractice, based on an analysis of data supplied by the National Practitioner Data Bank, is that the overall rate of paid claims is decreasing. From 1992 to 2014, the overall rate of paid claims dropped 55.7%.[7] To varying degrees, the drop in paid claims has occurred across all specialties, with internal medicine in particular dropping 46.1%. The reason for this decrease in paid claims is not clear. Improvements in patient safety are one possible explanation, with tort reforms also possibly contributing to this trend. An additional potential factor, which will likely become more important as it becomes more widespread, is the advent of communication and resolution programs (also known as disclosure, apology, and offer programs).

In communication and resolution programs, the response to a malpractice claim is to investigate the circumstances surrounding the adverse event underlying the claim to determine if it was the result of medical error. When the investigation finds no medical error, then the claim is defended. However, in cases in which there was a medical error leading to patient harm, then the error is disclosed to the patient and family, and an offer of compensation is made.

One of the most prominent communication and resolution programs exists at the University of Michigan, and published experience from this program shows that, after implementation of the program, significant drops were seen in the number of malpractice lawsuits, the time it took to resolve malpractice claims, the amount paid in patient compensation on malpractice claims, and the costs involved with litigating malpractice claims.[8] One of the goals of communication and resolution programs is to utilize the information from the investigations of whether medical errors occurred to find areas where patient safety systems can be improved, thereby using the medical malpractice system to promote patient safety. Although the University of Michigan's experience with its communication and resolution program is very encouraging, it remains to be seen how widely such programs will be adopted. Medical malpractice is primarily governed at the state level, and the liability laws of some states are more conducive than others to the implementation of these programs.

Hospitalist concerns about medical malpractice are likely to persist, as being named in a malpractice lawsuit is stressful, regardless of the outcome of the case. Contributing to the stress of facing a malpractice claim, cases typically take 3-5 years to be resolved. However, the risk for hospitalists of facing a medical malpractice claim is relatively low. Moreover, given national trends, hospitalists' liability risk would be expected to remain low or decrease moving forward. TH

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The opioid epidemic and its impact on the health care system

Hospitalists a part of multifaceted approach to the crisis

The United States is in the midst of a public health crisis. Every day, 91 Americans die from opioid overdoses.[1] Opioid addiction has a tremendous negative effect on parents and children by destroying lives and breaking up families. When used appropriately, these drugs, such as morphine, hydrocodone, oxycodone, and fentanyl, provide much needed pain relief to patients, especially after a surgical procedure or during treatment for cancer. Unfortunately, opioids also have qualities that make them addictive and prone to overuse and abuse.

Heroin and other opioid drugs are affecting social, health, and economic welfare in communities throughout the United States. Opioid addiction does not discriminate among occupations, socioeconomic statuses, or ethnicities. Once addicted, users find it difficult to fight and overcome the habit. In this context, hospitalists who develop and use opioid policies and tactics are better equipped to deal with the increasing prevalence of opioid addiction and overdoses seen in the medical center environment.

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Overview of opioid addiction

Opioids are more prevalent and easily available today in part because of the intense marketing campaigns by pharmaceutical companies. In fact, according to the 2014 National Survey on Drug Use and Health, almost 2 million Americans were dependent on or abused prescription opioids.[2] Opioids create artificial endorphins in the brain, amplifying positive feelings and euphoria. Once they become dependent, patients feel sick and become depressed when they aren't using narcotics. They experience uncontrollable cravings, relieved only by increasing opioid use. Personal relationships and finances are severely affected because patients will do whatever they can to acquire more opioids. Some resort to doctor shopping to obtain more opioids, while others will engage in drug trafficking to purchase and sell narcotics. Most new heroin users report that they started with nonmedical use of opioid pain relievers.[3]

Unfortunately, in 2015, there were more than 20,000 prescription opioid overdose deaths and almost 13,000 overdose deaths related to heroin.[4] In addition to addiction and death, overuse of narcotics can cause many medical issues, including dizziness, constipation, depression, and immune dysfunction.

As with any addiction, there are many problems related to opiate withdrawal. Some of these include anxiety, rhinorrhea, lacrimation, piloerection, mydriasis, nausea, vomiting, abdominal pain, diarrhea, tachycardia, and hypertension. Methadone, buprenorphine, and extended-release naltrexone typically are used to help alleviate cravings and the symptoms of withdrawal. With more than 1,000 patients treated daily by emergency departments for misuse of prescription opioids, it's imperative for the medical community to address this health care crisis.[5]

Impact on first responders and hospitalists

The impact of this epidemic on the medical community is dramatic. Emergency system resources, already on overload, are further taxed and drained by the increased 911 calls for overdose incidents. This means that, instead of responding to heart attacks, strokes, or other emergencies, first responders are spending time stabilizing overdose patients and taking them to hospitals. This resource drain spreads to emergency rooms and hospitals as they treat these patients. Eventually, the epidemic results in higher insurance costs to cover the impact on medical resources.

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Strategies for hospitalists

A multifaceted approach is required to combat this crisis, and hospitalists are one component of that solution. Here are strategies hospitalists can employ to combat the growing use and abuse of narcotics:

- **Screen for high-risk conditions.** Before prescribing opioids, screen patients for conditions that may be exacerbated by opioid use, including sleep apnea, obesity chronic obstructive pulmonary disease, and heart failure, as well as whether they are using medications that cause sedation and respiratory depression.
- **Develop and follow pain management clinical pathway protocols.** For example, start with nonopioid analgesics, such as acetaminophen, ibuprofen, and naproxen, for patients with mild pain. If the patient is in moderate pain, or if the mild pain was unrelieved by the first type of medicine, continue with opioid analgesics including codeine, oxycodone, hydrocodone, or morphine. Finally, if the patient is experiencing severe pain, or if the mild to moderate pain was unrelieved by previous medications, prescribe higher doses of morphine, fentanyl, or hydromorphone or use a patient-controlled analgesia delivery of an intravenous opioid.
- **Discuss other treatment options.** Instead of prescribing narcotics, assess whether other treatment options are viable. These include physical and occupational therapy, steroid shots, massage, local nerve blocks, and muscle relaxers.
- **Evaluate the reason(s) for current use of prescribed narcotics.** It's crucial to determine why patients are using opioids. The medical condition for which they were prescribed these medications may have resolved. If patients are using opioids without a medically indicated reason, offer alternative medications, such as methadone or naltrexone, and provide education to help them slowly taper off the drugs. Do not cease opioid use altogether unless the use is contraindicated because of other medical conditions or unstable vital signs (for example, low blood pressure).
- **Train nurses on opioid use and addiction.** Educate nurses about opioid addiction risk factors and symptoms of addiction. Instruct them on managing the Ramsay Sedation Scale and using an opioid sedation scale with patients receiving IV narcotics.
- **Educate families on opioid use and addiction.** Counsel patients and their families on the long-term effects of opioid use and about the warning signs of addiction. Teach them about alternatives to narcotics.
- **Offer referrals to specialized clinics.** Work with social workers, case managers, and local mental health professionals to refer patients to behavioral counseling, patient and family support groups, and monitored detoxification clinics qualified to treat opioid addiction.

Socioeconomic impact

The effects of the opioid epidemic are felt in all areas of the United States, especially in the health care industry. Emergency department visits are mounting while billions of dollars are spent on medical care for those addicted to opioids. Additionally, the socioeconomic effects of this crisis contribute to increasing depression, anxiety, missed days of work or school, unemployment, drop-out rates, and loss of productivity among those addicted to opioids. Also, the epidemic is adversely affecting families, leading to increased divorce rates, single-parent families, and child abuse and neglect. By creating strategies and protocols for medical staff, patients, and families affected by opioid use, addiction, or overdose, hospitalists can have a positive influence on patients' lives and ultimately the opioid epidemic. TH

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The Hospitalist

Improving the risk assessment of patients with acute pulmonary embolism

Hospital-based physicians may be doing a suboptimal job of data collection

Who doesn't like alphabet soup? Those noodles shaped as letters floating in a delicious hot broth serve as an educational way for young children to play with their food. Of course, this commentary is not about warm food suitable for a cold day but, instead, about another notion of alphabet soup – a metaphor for physicians' failure to optimally utilize our alphabet soup of venous thromboembolism studies.

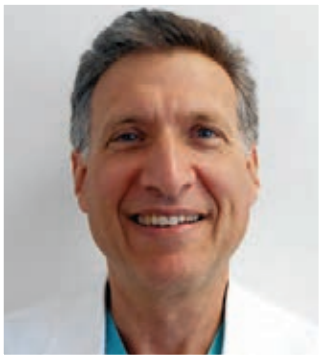
The medical literature that has studied the incidence, prevalence, diagnosis, and management of acute pulmonary embolism (PE) is vast. Yes, we have our own PE "alphabet soup" – a "hodgepodge especially of initials," according to the Merriam-Webster Dictionary. ICOPER (International Cooperative Pulmonary Embolism Registry) and RIETE (Computerized Registry of Patients With Venous Thromboembolism) help estimate prevalence of the disease and indicate high-risk groups. PESI (Pulmonary Embolism Severity Index) and PERC (Pulmonary Embolism Rule-Out Criteria) provide useful predictive information prior to proceeding with diagnostic testing for PE. The PEITHO (Pulmo-

nary Embolism Thrombolysis), MOPETT (Moderate Pulmonary Embolism Treated With Thrombolysis), and PERFECT (Pulmonary Embolism Response to Fragmentation, Embolectomy, and Catheter Thrombolysis) studies help to guide the decision to administer fibrinolytic therapy, particularly in the cases of so-called submassive or intermediate-risk PE.

We have no shortage of registries, scoring criteria, and clinical studies standing by to guide us in the management of acute PE. With this plethora of acronyms in scholarly publications, it would seem that health professionals should be well informed and better prepared to manage acute PE than ever.

And yet, in a study published in Hospital Practice (2017 Aug 30. doi: 10.1080/21548331.2017.1372033), my colleagues and I showed that, to a large extent, physicians admitting patients to the hospital between 2011 and 2013 for acute PE failed to order or perform even the most basic noninvasive testing on their patients, despite strong recommendations for such testing from both the 2011 American Heart Association (AHA) and the 2014 European Society of Cardiology as part of the risk assessment of acute PE.

At the time of the patients' PE admissions, the 2011 AHA statement already had been published, and it was recognized that medical and interventional therapies needed to be appropriate to the characteristics of the patient with PE. Specifically, in order to determine a prognosis, assessment of right heart strain with an echocardiogram, ECG, and brain natriuretic peptide testing was recommended. For similar reasons, a serum troponin test was recommended to evaluate any myocardial necrosis.



Dr. Scharf is medical director of pulmonary outpatient services at the Jane and Leonard Korman Respiratory Institute at Jefferson Medical College, Philadelphia. He is also director of the pulmonary vascular disease program at Jefferson.

While the 2011 AHA statement was based on a preponderance of evidence-based medicine, our research suggests that physicians may be doing a suboptimal job of collecting the necessary data to manage our acute PE patients. In defense of those physicians we evaluated, these data were collected just before the European Society of Cardiology disseminated their recommendations for risk stratification in 2014. The PEITHO, MOPETT, and PERFECT findings – though already presented at medical meetings in part – were not published in scientific journals in full until 2013 or thereafter.

Nevertheless, I believe these findings illustrate the merits of the Pulmonary Embolism Response Team (PERT) concept. As the data we studied suggest, not only might hospital-based physicians inadequately assess the severity of patients' PE, but they also may fail to ask for consultations from the specialists who could be most useful in assisting in the proper evaluation and management of these patients. PERTs ensure that every patient admitted to the hospital with the diagnosis of PE will be assessed by a team of physicians with the expertise and professional interest in best managing these patients.

The expectation is that, with the institution of a PERT at each hospital, a more comprehensive evaluation of patients' PE may lead to optimal management and, thereby, to improved short- and long-term outcomes. Also, we should not assume that a greater degree of expertise and imaging capabilities at an academic university hospital translates to a more comprehensive evaluation of PE; our research shows that this is not necessarily the case. PERTs may help mobilize resources that are underutilized even at academic university hospitals. Those interested in learning more about PERTs may contact the National PERT Consortium via email at contact@pertconsortium.org or go online to www.pertconsortium.org.

Rather than wallow in an alphabet soup of acronyms, let us place our acronymic clinical PE trials to good use. Gather the appropriate clinical data, consult experts in pulmonary embolism, and stratify patients admitted to the hospital with acute PE so that we can manage the expectations of short- and long-term outcomes.

When he became president in 1933, Franklin D. Roosevelt sought to lift the United States from the Great Depression, in part with a New Deal "alphabet soup" of programs. Like FDR, let us put our own alphabet soup – of PE studies and position statements – to good use: to work for the good of people hospitalized with acute pulmonary embolism. TH

Reducing Harm

CONTINUED FROM PAGE 1


Dr. Auron

a conversation and encouraging physicians to interrogate their habits – Choosing Wisely has been a success.

"It's brought a lot of awareness about the problem of matching best evidence with the patient you have in front of you," said John Bulger, DO, MACP, MBA, SFHM, chief medical officer of Geisinger Health Plan. "Some people call that evidence-based medicine, but the problem with calling it that is that you can have a study, but it may not match up with the patient you're seeing right now. There are many things we do because we did them in the past or because we didn't have all the information, and I think Choosing Wisely has made people think twice about some of the things they do."


Dr. Bulger

To help communicate these messages to patients, Choosing Wisely partnered early on with Consumer Reports, and hospitalists count that partnership as another success. By producing reports, brochures, and videos that translate medical language into layman's terms and offer patients specific advice about talking with their provider – all under the trusted Consumer Reports name – the company provides tools for physicians to make these conversations transpire more efficiently.

The message of Choosing Wisely continues to spread, even internationally. It's now present in 18 countries, Mr. Wolfson said. "We're also seeing on the horizon many state efforts, such as in Connecticut and Rhode Island; and Delaware is organizing a statewide effort. I see that as the next big thing: statewide efforts that pair delivery systems with multistakeholder groups, regional health collaboratives, and physician organizations, all working to reduce use."

As it spreads, Choosing Wisely is sparking a new generation of related initiatives, such as Costs of Care and Johns Hopkins' High Value Practice Academic Alliance. There's a new section in the Journal of Hospital Medicine called "Things We Do for No Reason" highlighting different practices each month, and a nationwide Student High Value Care Initiative introduces value concepts to medical students. "It's not Choosing Wisely by itself; it's provided the backbone for all these new efforts," Dr. Auron said.

Challenges remain

While it has spread, Choosing Wisely also has met some obstacles. Among them is that even with the help of Consumer Reports' tools, the physician-patient conversations can be difficult. A behavioral economics concept called loss aversion is part of the reason: It's basic human nature to feel the pain of loss more acutely than the pleasure of gain.

> I see that as the next big thing: statewide efforts that pair delivery systems with multistakeholder groups, regional health collaboratives, and physician organizations, all working to reduce use.
>
> —*Daniel Wolfson, executive vice president and chief operating officer of ABIM*

"It's part of what makes that conversation with the patient so difficult from the provider's side – that idea that taking away care from them can actually be better for them," said Alexander Mainor, JD, MPH, research project coordinator at the Dartmouth Institute, which published "Physician perceptions of Choosing Wisely and dDrivers of overuse."[2]


Mr. Mainor

"It's tough because that conversation requires specific training," he said. "It's one thing to tell the clinician, or to have it pop up on an EHR, that provision of an antibiotic for this clinical presentation is not appropriate. However, it's an entirely different thing to look a patient in the face who comes in expecting a course of antibiotics and tell them that they're not going to get it."

Another hurdle is the existing fee-for-service system, which obviously does not promote cost consciousness. Since there's really no disincentive to a physician ordering an additional test, acceptance of Choosing Wisely can vary widely between institutions. "Choosing Wisely permeated very nicely here at the Cleveland Clinic," Dr. Auron said. "But other hospitals – especially private hospitals that are not owned by doctors – what they want is just the service line."

Physicians' discomfort with uncertainty is another challenge, according to Mr. Mainor. "A lot of it can be by virtue of medical training and how particular residents were taught to always run this panel when you have this presentation," he said. "Sometimes it's hard to separate Choosing Wisely from the concept of defensive medicine, but this is more wanting to be able to tell the patient that you did everything that you could before proceeding to a particular next step or treatment."

Getting patient input from the outset and making sure goals are aligned can help with some of these issues – but can itself be a hurdle.

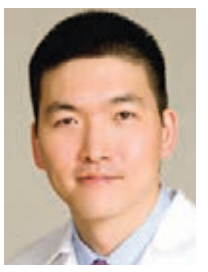
"That's the patient-centered part of this process that I think is very important and is always a challenge," said Harry Cho, MD, FACP, director of quality, safety, and value for the division of hospital medicine at Mount Sinai in New York. "Doctors need to understand patients, too. Their thought may be, 'I want more tests so that the doctor can make a better decision.' Understanding where that knowledge gap is and what we need to do in terms of education and reaching out to patients and making the decision together, I think, will be very helpful."

The road ahead

The time it takes to have these conversations is more than a sticking point for Choosing Wisely, it's an underlying challenge in our health care system.

"For example, it takes more time to have a discussion about what the alternatives are to alleviate pain – other than taking an opiate," Dr. Bulger said. "The easiest thing to do is to write the script for the opiate – which is part of the reason why we got where we are with opioids – or to write the script for an antibiotic – which is part of the reason why we got here with drug resistance. We haven't done a great deal to address those underlying drivers. Without doing that, you can only go so far with a campaign like Choosing Wisely."

Issues around costs fall into a similar category: an underlying issue that demands a broader conversation. "It's just so elusive," Dr. Cho said. "There are so many different versions of cost, and from a hospital medicine standpoint, that process is so prolonged. We may not touch base with that patient when they get their bill, so for us to have a conversation about exactly how much this would cost can be difficult. It's so complex; I would love for that to be tackled so that it's a little more straightforward."


Dr. Cho

Perhaps these additional conversations will start to happen as value becomes a more defined career path in hospital medicine and as the ideas behind Choosing Wisely continue to move to the forefront.

"There are people involved in career paths in education, quality and safety, research, and administration, but there are very few people actually focused on value – and then finding the resources and the mobilization to do that," Dr. Cho said. "I think it would really be helpful moving forward to find more people doing this and getting more support from their organizations."

In one step toward that goal, a value track has been added to the Society of Hospital Medicine annual meeting.

"I think you're going to see more emphasis on this, especially with younger hospitalists that are really pushing the value theme," Dr. Bulger said. "I think those are really the lessons learned in what we started with Choosing Wisely." TH

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How hospitalists can focus on health equity

Achieving health equity requires removing the 'obstacles to health'

By Kelly April Tyrrell

A decade ago, most hospitalists and hospital leaders were not thinking about health equity, let alone discussing it.

"It used to be we could say: 'We saved your life but everything else is beyond our control,'" said Nick Fitterman, MD, FACP, SFHM, vice chair of Hospital Medicine at Northwell Health in New York, and associate professor of medicine at Hofstra Northwell School of Medicine and Long Island Jewish Medical Center.

But today?

"We have a better understanding that what affects the health of most of our patients is what happens outside the four walls of the hospital," he said. "Now, we can work with case managers and community-based organizations to help address housing and food. We can at least steer our patients to resources and help them with the social determinants of their health."

That's because the social determinants of health – diet, inactivity, substance abuse, poverty, and more – "account for nearly 75% of disease," said Kevin Smothers, MD, FACEP, vice president and chief medical officer at Adventist HealthCare Shady Grove Medical Center in Rockville, Md. "Health care providers are only able to 'fix' about 15% of the causes of poor health."

A report recently published by the University of California, San Francisco, and the Robert Wood Johnson Foundation (RWJF) takes on the definition of health equity.[1] Because, as one of the report's authors, Paula Braveman, MD, MPH, professor of Family and Community Medicine and director of the Center on Social Disparities in Health at UCSF, argued in a Health Affairs blog post in June 2017: "Clarity is particularly important because pursuing equity often involves engaging diverse audiences and stakeholders, each with their own constituents, beliefs, and agendas. And in an era of data, a sound definition is crucial to shape the benchmarks against which progress can be measured."

Measurement is an unavoidable aspect of the practice of medicine in the 21st century and both Dr. Fitterman and Dr. Smothers say hospitals must start focusing on the nonmedical factors that influence health to find success.

"Payment reform is forcing delivery reform," Dr. Fitterman said.

A report from the National Academies of Sciences, Engineering, and Medicine estimates that racial health disparities alone – not including other marginalized groups – could cost health insurers as much as $337 billion between 2009 and 2018.[2] "Hospitals and hospitalists have to focus on health disparities in order to address the multitude of chronic medical conditions they treat," said Dr. Smothers.

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For the purposes of measurement, the authors of the RWJF report conclude that "health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups." The report attempts to define health equity as a means of specifically addressing it.

"Population health means taking care of the wider population, in terms of health and cost," said Dr. Fitterman. "But if you're just looking at the average health of a population you could still be missing pockets of disparity, since there will be pockets that excel and pockets of disparity but the average looks good. If we're not careful how we measure it, we may leave some groups behind."

Achieving health equity, the RWJF report says, requires removing the "obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." Health equity means that everyone must have "a fair and just opportunity to be as healthy as possible."

It lays out four "key steps" to achieve health equity: 1. Identify important health disparities; 2. Change and implement policies, laws, systems, environments, and practices to reduce inequities in the opportunities and resources needed to be healthier; 3. Evaluate and monitor efforts using short- and long-term measures; and 4. Reassess strategies in light of process and outcomes, plan next steps.

Everyone can be a part of the solutions to address health disparities, Dr. Fitterman said. He was not involved in the report. For hospitalists interested in addressing health equity, Dr. Braveman had two recommendations:

- Choose to practice at a hospital that serves large numbers of socially disadvantaged people;
- Put particular effort into helping the most socially disadvantaged patients in their hospitals.

This should include understanding the conditions that bring disadvantaged people to the hospital in disproportionate numbers, Dr. Braveman said, and getting involved in initiatives intended to address them. For example, after observing that disproportionate numbers of poor kids are hospitalized with asthma, hospitalists might connect with community groups that can help address pest abatement in low-income housing.

Health equity efforts should not just focus on socioeconomically or racially disadvantaged groups either, Dr. Braveman and Dr. Fitterman argue. They must also address others who are marginalized, like patients who are disabled, elderly, obese, non–English speaking, or gender nonconforming.

Dr. Fitterman said his hospital leadership has made health equity a priority and believes successful health equity practices involve good leadership, becoming aware of and addressing unconscious bias, and efforts to address the social determinants that can cut through health disparities.

"The focus of our last leadership retreat was diversity and health disparities," Dr. Fitterman said. "It starts at the top down. I bring that to our faculty and site directors: Everyone takes an online test to raise their awareness of unconscious bias."

Dr. Smothers serves on the board of the Center for Health Equity and Wellness at Adventist HealthCare, which works to improve access to "culturally appropriate care, and provides community wellness outreach and education." He said that, in addition to programs at the Center which address disparities, his hospital has also established teams of doctors, nurses, case managers, and transitional care nurses to help redirect patients to "more appropriate, less costly services, such as primary care, urgent care, home care, and subacute care," when it is in the patient's best interest.

> That's because the social determinants of health – diet, inactivity, substance abuse, poverty, and more – 'account for nearly 75% of disease. Health care providers are only able to "fix" about 15% of the causes of poor health.'
>
> –Kevin Smothers, MD, FACEP,

Not only are Adventist's hospitalists aware of community resources available to their patients, they are also culturally diverse, Dr. Smothers said, noting that they are "well equipped to manage our diverse patient population, including those who lack adequate health care."

Additionally, Dr. Smothers said: "We engage our hospitalists in care coordination, encouraging them to make recommendations on alternative treatment locations and/or options at the point of entry." And all admitted patients with chronic conditions are provided with a month's supply of medication and schedule transportation for their follow-up appointment upon discharge.

"We need to inquire about social determinants that may prohibit our success with our patients," said Dr. Fitterman. "You are not always going to be able to fix it, but it doesn't mean you shouldn't try." TH

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QUALITY

New curriculum teaches value-based health care

Hospitalist-developed content is applicable to 'our day-to-day world.'

While value has become an imperative in both training and health care delivery, few tools exist to teach hospitalists and other providers the basic concepts of value.

"Hospitalists are on the front lines of health care value delivery, and it is critical that we understand and embrace the concepts of value; however, we also need to be able to deliver upon these ideals," said Christopher Moriates, MD, assistant dean for health care value at the University of Texas at Austin.

Dr. Moriates developed a free online core curriculum called "Discovering Value-Based Health Care." "We built 'Discovering Value-Based Health Care' to serve as an adaptive learning resource for clinicians at all levels – from medical school through practicing physicians," he said. The first module, "There's a Better Way," is available now.

"As a hospitalist, I ensured that the content would be specifically applicable to our day-to-day world and experience," Dr. Moriates said. "Using the modules, hospitalists can better understand how emerging tools, such as the University of Utah's Value-Drive Outcome tool, can be used by hospitalists to improve value. The modules also dig into thorny subjects like understanding health care costs – for example, what really is the difference between costs and charges?"

Dr. Moriates

The course is adaptive and interactive, using the latest in instructional technology, he said. Hospitalists can take the course independently and earn free CME credits; those who complete all three modules in this first collection will receive a certificate of completion and CME credit.

The goal is to release 10 modules over the course of this academic year, Dr. Moriates said. Future collections will cover "value-based health care delivery," "how to deliver high-value care at the bedside," and "how to deliver high-value care in systems."

"As value-based health care is increasingly taught in medical schools and residency training, it is important for hospitalists – especially any of us that work with trainees – to be able to speak the same language and understand what our trainees now will know," he said. TH

QUALITY

Consider 'impactibility' to prevent hospital readmissions

Link predictive models to actionable opportunities for improving care

With the goal of reducing 28-day or 30-day readmissions, some health care teams are turning to predictive models to identify patients at high risk for readmission and to efficiently focus resource-intensive prevention strategies. Recently, there's been a rapid multiplying of these models.

Many of these models do accurately predict readmission risk, according to a recent BMJ editorial. "Among the 14 published models that target all unplanned readmissions (rather than readmissions for specific patient groups), the 'C statistic' ranges from 0.55 to 0.80, meaning that, when presented with two patients, these models correctly identify the higher risk individual between 55% and 80% of the time," the authors wrote.

But, the authors suggested, the real value is not in simply making predictions but in using predictive models in ways that improve outcomes for patients.

"This will require linking predictive models to actionable opportunities for improving care," they wrote. "Such linkages will most likely be identified through close collaboration between analytical teams, health care practitioners, and patients." Being at high risk of readmission is not the only consideration; the patient must also be able to benefit from interventions being considered – they must be "impactible."

"The distinction between predictive risk and impactibility might explain why practitioners tend to identify quite different patients for intervention than predictive risk models," the authors wrote.

But together, predictive models and clinicians might produce more effective decisions than either does alone. "One of the strengths of predictive models is that they produce objective and consistent judgments regarding readmission risk, whereas clinical judgment can be affected by personal attitudes or attentiveness. Predictive risk models can also be operationalised across whole populations, and might therefore identify needs that would otherwise be missed by clinical teams (e.g., among more socioeconomically deprived neighbourhoods or groups with inadequate primary care). On the other hand, clinicians have access to a much wider range of information regarding patients than predictive risk models, which is essential to judge impactibility."

The authors conclude, "The predictive modelling enterprise would benefit enormously from such collaboration because the real goal of this activity lies not in predicting the risk of readmission but in identifying patients at risk for preventable readmissions and 'impactible' by available interventions." TH

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QUICK BYTE

TAKE A SEAT: Enhancing patient satisfaction

A survey of 305 inpatients showed that patients who reported that at least one provider sat down while caring for them were more likely to feel that their provider spent appropriate time with them and that their provider kept them well informed. The authors concluded that sitting down at a patient's bedside improves some aspects of patients' and families' experience of their hospital care, and should be included in hospital efforts to improve the patient experience. TH

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QUALITY

Using 'design thinking' to improve health care

Groups naturally coalesce to solve problems

Health care workers creating innovations by applying "design thinking" – "a human-centered approach to innovation" that comes from the business world – is a growing trend, according to a recent New York Times article.

"With design thinking, the innovations come from those who actually work there, providing feedback to designers to improve the final product," wrote author Amitha Kalaichandran, MD, MHS.

"Health providers ... are uniquely positioned to come up with fresh solutions to health care problems," Dr. Kalaichandran wrote. An example at her own hospital: The leader of the trauma team now wears an orange vest, clearly identifying who's in charge in a potentially chaotic situation. It was an idea created by a hospital nurse.

"A 2016 report that looked at ways in which a health system can implement design thinking identified three principles behind the approach: empathy for the user, in this case a patient, doctor or other health care provider; the involvement of an interdisciplinary team; and rapid prototyping of the idea," she wrote. "To develop a truly useful product, a comprehensive understanding of the problem the innovation aims to solve is paramount."

In design thinking, described as creative, multidisciplinary thinking around a problem, groups naturally coalesce to find such solutions. The article cites examples such as Clinicians for Design, an international group of providers focused on improving hospital layouts, and Health Design by Us, a collaborative group that supports health care innovations such as a mobile system for diabetes management, designed by a patient.

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TECHNOLOGY

Reducing outpatient medication costs

Empowering clinicians is essential

For many patients, paying for medication presents a serious challenge. Studies show that up to 45% of Americans do not fill prescriptions secondary to cost, and medication nonadherence leads to morbidity and mortality, with costs from $100 billion to $300 billion annually.

Dr. Kubey

One way to address the problem is by empowering clinicians to reduce patient outpatient medication costs – the goal described in a recent abstract.

The researchers partnered with GoodRx to provide prescription pricing and discount information. "We used this data to create a new proprietary algorithm-based tool to further reduce prescription cost," wrote lead author Alan A. Kubey, MD. "Leveraging a combination of therapeutic interchange and analysis of medication dose, formulation, quantity, pharmacy, and available discounts, we are able to identify the most high-value therapeutic choice for a particular patient."

Initial testing was promising. One patient, admitted for the fourth time in 14 months for hypertriglyceridemia-induced pancreatitis secondary to medication nonadherence, was able to reduce 90-day outpatient medication cost by 95%, from $1,287.00 to $61.79. By reducing his readmissions, the institution saved more than $20,000 a year.

The researchers secured internal grant funding to develop an automated version of the tool. "We currently have technology that can dramatically reduce the cost of many medications with early promising results for patient outcomes, readmissions rates and overall systemic cost," Dr. Kubey said. "We are working rapidly to further develop and study our tool and, if prospective results confirm our initial findings, we will seek to provide this tool to clinicians broadly."

Such tools are a true win-win. Hospitalists using them help ensure that discharged patients are able to afford the often life-saving medications that will keep them healthy and out of the hospital, improve readmission rates, patient satisfaction metrics, total system cost, and, most important, do right by our patients in need for whom we are charged to care, Dr. Kubey said.

TMdesstock

"Hospitalists first must be aware that savings of 90% or more are possible for many medications and that medication nonadherence because of cost is a serious issue affecting nearly half the patients we see," he said. "The first step is simply asking patients if medication cost is proving troublesome – we cannot address what we do not see. The second step is to use current discount tools such as GoodRx, NeedyMeds, and the like – and, we hope, in the not too distant future, our tool, which we plan to integrate into EHR prescribing to make it easy and nearly instantaneous for hospitalists to prescribe the most high-value, low-cost medication regimen for each individual patient at discharge." TH

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KEY POINTS

- Hospitalists are in a unique position to identify patients with peripheral vascular disease when they are admitted with SSTIs.
- For patient assessment, it is important to consider PAD and CVI separately.
- The classic symptom for PAD is claudication. In contrast, symptoms of CVI present more variably.
- Other than cases of critical limb ischemia, the main objective of identifying PAD or CVI is to arrange testing and follow-up after discharge.

Introduction

Skin and soft tissue infections (SSTIs) remain among the most common inpatient diagnoses cared for by hospitalists. Most patients admitted to a hospitalist service with an SSTI meet the criteria for either moderate or severe infection as outlined by the Infectious Disease Society of America (IDSA) – systemic signs of infection by SIRS criteria or a high likelihood of an immunocompromised state, methicillin-resistant *Staphylococcus aureus* (MRSA) infection, trauma, or wounds.[1]

Often these patients have several comorbid conditions such as diabetes, morbid obesity, or peripheral arterial and venous disease. Though most hospitalists are adept at managing diabetes, blood pressure, and other comorbidities, the ability to recognize and manage peripheral vascular disease can be challenging. This article will discuss ways to help providers better identify and manage underlying peripheral arterial disease (PAD) and/or chronic venous insufficiency (CVI) in patients admitted with lower extremity SSTIs.

1 In addition to an infection, could there also be underlying peripheral arterial or venous disease?

Patients with peripheral edema and vascular disease are predisposed to recurrent lower extremity SSTIs. For assessment of vascular disease, it is important to consider PAD and CVI separately.

CVI refers to the spectrum of syndromes caused by venous valvular incompetency, venous obstruction, or decreased muscle contraction. Veins cannot maximally deliver venous blood back to the heart resulting in venous pooling in the lower extremities. The exact mechanism of the skin changes that accompany venous insufficiency is unknown but may be related to cytokine cascades that result in perivascular inflammation and a weakening of the dermal barrier. Over time, this can develop into spontaneous ulceration of the skin.[2,3]


Dr. Nigalaye

PAD refers to atherosclerosis of the noncerebral, noncoronary arteries, which leads to ischemic symptoms and atrophy of the supplied territory. Ulceration usually results from mild trauma due to poor wound healing.[4,5] A thorough history, assessment of risk factors, and physical exam are essential to identifying these two potential diagnoses in patients admitted with SSTIs.

First, the provider should assess risk factors for underlying vascular disease. For PAD, these include risk factors similar to those of coronary artery disease (CAD): hypertension, hyperlipidemia, history of smoking, and poorly controlled diabetes. Chronic kidney disease and family history are also associated with PAD. Since PAD and CAD share similar risk factors, it is often common for patients with CAD (as well as patients with cerebrovascular disease) to have PAD. Risk factors for CVI include obesity, chronic sedentary lifestyle, multiple pregnancies, family history, and prior superficial or deep venous thrombosis.[2,4]

Next, the provider should ask the patient about symptoms experienced prior to the onset of the current SSTI. Patients with either arterial or venous disease will typically report lower extremity symptoms that have been occurring for months to years, long before the acute SSTI. The classic symptom for PAD is claudication – leg pain or cramping that occurs on exertion and improves with rest. This is due to decreased arterial blood flow to the affected limb, felt most acutely during exercise. Other symptoms include numbness, a cool lower extremity, and lower extremity hair loss. As PAD progresses, a patient may also have rest pain, which may indicate more critical ischemia, as well as nonhealing wounds after mild trauma.

In contrast, symptoms of CVI present more variably. CVI can be associated with heaviness, cramping, and pain that are usually worse in the dependent position and relieved with elevation. Patients may also report dry skin, edema, pruritus, scaling, skin tightness, and indolent ulcers at advanced stages.[2-6]

The physical exam can help the provider distinguish between venous and arterial disease. Patients with PAD often have diminished or nonpalpable distal pulses, bruits in proximal arteries, pallor, hair loss, nail thickening, decreased capillary refill time, and ulceration of the toes. CVI shares some common characteristics but can be distinguished by evidence of varicose veins, telangiectasia, edema (which spares the foot), lipodermatosclerosis, and atrophie blanche (white scarring around the ankle). Patients with venous disease tend to have warm lower extremities and palpable pulses. Often, there is hyperpigmentation, especially around the ankles, and associated eczematous changes with scaling, erythema, and weeping. CVI can also present with ulcers. In addition, if the SSTI is not responding to appropriate antibiotics in the typical time frame, this may be a clue that there is an underlying vascular issue.[2-6]

Ulcers, whether arterial or venous, comprise a break in the skin's protective barrier and give bacteria a point of entry. Thus, ulcers often get superinfected, leading to an SSTI rather than SSTIs causing ulcers. The anatomic location can help differentiate between venous and arterial ulcers. Arterial ulcers tend to occur on the toes, heels, and lateral and medial malleoli. Venous ulcers are classically present above the medial malleolus but can occur anywhere on the medial lower third of the leg. Venous ulcers are more superficial and have an irregular shape, while arterial ulcers are deeper and have smoother edges and a "punched-out" shape. Both arterial and venous ulcers can be exudative though venous ulcers are rarely necrotic. Both arterial and venous ulcers can be painful.[7-9]

2 There are signs and symptoms of underlying vascular disease in a patient with a lower extremity SSTI … Now what?

Neither PAD nor CVI is a clinical diagnosis, thus further work-up is required to confirm the diagnosis and accurately classify disease severity. The timing of this work-up is of unique interest to hospitalists.

Most patients who are hospitalized with cellulitis or a superficial wound infection do not need urgent inpatient work-up of suspected peripheral arterial or venous disease. The one notable exception to this is patients with diabetic foot infections or infected arterial ulcers that need prompt evaluation for possible critical limb ischemia. Other than cases of critical limb ischemia, the main objective of identifying PAD or CVI in patients hospitalized for SSTIs is to appropriately arrange testing and follow-up after discharge.

As for specific management strategies, it is useful to stratify patients by symptom and exam severity as follows: mild/moderate PAD symptoms without ulcer; infected ulcer with PAD features; mild/moderate CVI symptoms without ulcer; and infected ulcer with CVI features. As specific guidelines for the inpatient work-up and management of suspected peripheral arterial and venous disease are sparse, we rely on guidelines and best practices used in the outpatient setting and adapt them to these potential inpatient presentations.

Mild/moderate PAD symptoms with superimposed cellulitis but no ulceration

In a patient admitted for cellulitis without open wounds, history and review of systems might reveal the presence of claudication or other symptoms suspicious for PAD. While the U.S. Preventative Services Task Force (USPSTF) and Amer-

ican College of Cardiology (ACC) discourages the routine screening of asymptomatic patients for PAD, patients with risk factors who exhibit symptoms should undergo initial testing for PAD with an ankle-brachial index (ABI).[10]

The ABI is the ratio of ankle blood pressure to arm blood pressure, and is measured via sphygmomanometry with a Doppler probe. The ABI remains the simplest, most inexpensive first-line test for PAD. An ABI value of less than 0.9 is considered diagnostic for PAD and has been found to be more than 95% specific for arterial stenoses of greater than 50% on angiography across multiple studies.[11]

In an inpatient with risk factors for PAD and claudication symptoms, referral for outpatient ABIs with subsequent follow-up by a primary care physician (PCP) should be arranged. If a diagnosis of PAD is made via ABI, the PCP should reinforce risk factor modification (tobacco cessation, diet, exercise, and aggressive lipid, blood pressure, and blood glucose control) and start medical management with a single antiplatelet agent to reduce the risk of MI, stroke, or "vascular death." The most recent ACC guidelines recommend either aspirin or clopidogrel as an acceptable antiplatelet agent (grade 1A).[12] Cilostazol may be considered if claudication symptoms are significantly interfering with lifestyle. If this management fails, the patient may be referred to a vascular specialist for consideration of revascularization.

Infected ulcer with PAD features

Unlike cellulitis, arterial ulcers are a direct sequela of arterial insufficiency and represent the far end of the spectrum of disease severity and in certain cases treatment failure. Patients who present with advanced ischemic and/or diabetic foot ulcers may have never been evaluated for PAD as an outpatient. Prompt work-up and management is required given the high degree of morbidity and mortality associated with arterial ulcers. Whether an urgent inpatient evaluation is indicated depends on the clinical evaluation.

The first step is to determine the depth of the ulceration. Critical limb ischemia may be present if the ulcer is deep, gangrenous, overlies a bony prominence, or is associated with systemic signs of sepsis. A physical exam should include an assessment of the pulses including femoral, popliteal, PT, and DP, preferably with bedside Doppler ultrasound. If pulses are absent, urgent vascular surgery evaluation is warranted to prevent loss of limb; the work-up generally involves imaging such as computed tomography angiography (CTA) or magnetic resonance angiography (MRA) to identify culprit lesions, or if sufficiently suspicious, immediate invasive angiogram with the potential for endovascular intervention.

While palpable pulses can be reassuring and raise the possibility of a nonarterial etiology of ulceration – such as a microvascular, neuropathic, or venous disease – it is important to remember that pulse exams are often unreliable and provider dependent.[13] Moreover, the presence of pulses does not effectively exclude severe PAD or critical limb ischemia in patients with a high pretest probability.[14] Thus, in cases of deep, complex lower extremity and foot ulcers, it is prudent to obtain urgent evaluation by a surgical wound specialist, which depending on the institution may be podiatry, vascular surgery, or wound care. This may lead to a better clinical assessment of the wound and clearer recommendations regarding the need for additional testing, such as imaging, to rule out osteomyelitis, surgical debridement, or amputation.

Inpatient ABIs in this situation may help diagnose and quantify the severity of PAD. Newer classification schemes such as the Society of Vascular Surgery WIfI score (Wound Ischemia Foot Infection) take into account clinical findings as well as ABI scores to better prognosticate limb loss and select patients for intervention.[15] If the clinical picture is deemed sufficiently suspicious for critical limb ischemia, the patient may be taken directly for invasive testing with possible intervention.

If an infected ulcer is superficial, shows no signs of gangrene, and has been present for less than 30 days, further work-up for suspected PAD can generally be deferred to an outpatient setting after resolution of the acute infection. Management of the wound is highly institution dependent. When available, a wound care specialist (physician or nurse) or a plastic surgeon can be consulted as an inpatient to give specific recommendations that can range anywhere from enzymatic debridement to simple dressing. If this service is unavailable, we recommend dressing the wound with moist nonocclusive dressings with frequent changes. Referrals for ABI testing and follow-up in podiatry, wound care, or vascular clinic should be arranged. Finally, educating the patient on what to expect can increase compliance with the outpatient treatment plan.

Mild to moderate CVI symptoms with superimposed cellulitis but no ulceration

Chronic venous insufficiency is a syndrome that has variable presentations based on the location and degree of valvular incompetence in the superficial or, less commonly, deep venous systems. For a patient with cellulitis and CVI, the clinical exam findings may be associated with venous hypertension syndrome – in which there is deep axial reflux and possible obstruction – and could also represent complex varicose disease which is usually caused by superficial reflux of the greater saphenous vein.[3] The lack of advanced skin changes and ulceration raises the suspicion of mild to moderate CVI.

Guidelines from the American Venous Forum and the Society for Vascular Surgery recommend that all patients with suspected CVI, regardless of severity, undergo venous duplex ultrasound scanning as a first diagnostic test (grade 1A) to accurately classify the disease according to the CEAP (Clinical Etiological Anatomical Pathophysiology) system (Table 1).[16]

This test is different from the routine lower extremity ultrasound used to diagnose acute venous thrombosis, as it must be performed by an experienced technician who evaluates the patient both lying and standing and uses maneuvers to help localize regions of reflux in the deep and superficial veins, as well as perforators.[17] This examination, occasionally called a "reflux study," is often unavailable in the inpatient setting and may not be reimbursed if obtained during a hospitalization. Hence, this patient with suspected CVI should be referred for duplex ultrasound examination upon discharge with follow-up in a primary care clinic. Furthermore, the patient should be advised to lose weight, partake in an exercise program, and elevate the extremities as much as possible.

Compression therapy is commonly accepted as a noninvasive treatment option for all levels of CVI, yet most of the evidence comes from secondary prevention studies in patients with advanced CVI with venous ulcers.[7] Strong evidence for the role of compression stockings in mild to moderate CVI is lacking. In fact, recent guidelines from the Society of Vascular Surgery, reviewed by the American Heart Association, do not recommend compression therapy as a primary treatment modality in patients with symptomatic varicose veins (without ulcers) if the patient is a candidate for saphenous vein ablation.[16] This recommendation is based on clinical trial data that showed greater efficacy and cost-effectiveness of surgery versus conservative management in patients with CEAP2 (low severity) CVI as well as studies noting noncompliance with compression therapy as high as 75%.[18,19]

However, determining a patient's candidacy for ablative or surgical therapy requires ultrasound data for accurate CEAP scoring, which is often not achieved as an inpatient. Given the potential benefit and lack of severe adverse effects, hospitalists can consider initiating compression therapy at the time of discharge in a patient with mild to moderate signs of CVI and a low risk profile for severe PAD. The prescription should specify knee-length elastic stockings with graduated compression between 20 and 30 mm Hg.[16] The patient should also be encouraged to complete the outpatient duplex ultrasound testing prior to the PCP visit so that he or she can be referred to a vascular specialist appropriately.

Infected ulcer with CVI features

If the patient's exam is suspicious for advanced venous disease with ulceration, the clinician should evaluate for the presence of scarring. This would indicate that there has been long-standing venous disease with recurrent ulceration. This patient should be asked about a previous diagnosis of CVI, prior compression therapy, and barriers to compliance with compression therapy such as poor fit or difficulty of use due to obesity or immobility. It is important to note that mixed ulcers are present in up to 20% of patients; a careful assessment of risk factors for PAD, pulse exam, and referral for outpatient ABI testing is warranted to rule out arterial insufficiency in this patient with likely venous ulcer.[20]

The AHA recommends prompt specialist evaluation for CEAP scores greater than or equal to 4; based on physical exam alone, this patient's active venous ulcer yields the highest possible score of 6.2 If not previously done, this patient with advanced CVI and ulceration should be referred for an outpatient venous duplex ultrasound as well as urgent follow-up with a vascular specialist soon after discharge.

There is significant consensus in the literature that multilayer compression therapy between 30 and 40 mm Hg is the first-line treatment in patients with venous ulcers as it has been shown to promote ulcer healing and prevent recurrence.[21,22] In addition, superficial venous surgery, including minimally invasive ablation, can reduce the recurrence of ulcers if used as adjunctive therapy in selected patients.[23] However, compressive therapy should generally not be prescribed in patients with venous ulcers until PAD has been ruled out.

If ABI results are available, the clinician can consider compression at 30-40 mm Hg for ABI values greater than 0.8 and reduced compression at 20-30 mm Hg for values of 0.5-0.8; compression is contraindicated if the ABI is less than 0.5. Prompt follow-up with a vascular specialist can help direct compressive and/or surgical therapy. Wound care consultation as an inpatient can assist with dressing recommendations,

CONTINUED ON PAGE 28

Table 1. CEAP classification of chronic venous disease

Clinical Classification (C)		Etiologic Classification (E)	
C_0	No visible/palpable signs of venous disease	E_c	Congenital
		E_p	Primary
C_1	Telangiectasias or reticular veins	E_s	Secondary (postthrombotic)
C_2	Varicose veins	E_n	No venous etiology identified
C_3	Edema	**Anatomic Classification (A)**	
C_{4a}	Pigmentation and/or eczema	A_s	Superficial veins
		A_p	Perforator veins
C_{4b}	Lipodermatosclerosis and/or atrophy	A_d	Deep veins
C_5	Healed venous ulcer	A_n	No venous location identified
C_6	Open venous ulcer	**Pathophysiologic Classification (P)**	
		P_r	Reflux
	Subscript	P_o	Obstruction
A	Asymptomatic	$P_{r,o}$	Reflux and obstruction
S	Symptomatic	P_n	No venous pathophysiology identifiable

Frontline Medical News

Source: Adapted from the 2011 Clinical Guidelines of the Society for Vascular Surgery and American Venous Forum (J Vasc Surg. 2011;53:2S-48S)

Though most hospitalists are adept at managing diabetes, blood pressure, and other comorbidities, the ability to recognize and manage peripheral vascular disease can be challenging.

though the evidence has not shown that dressings of any type worn under compressive garments improve ulcer healing.[24]

Bottom line

Hospitalists are in a unique position to identify patients with underlying peripheral arterial and venous disease when they are admitted for lower extremity skin and soft tissue infections. A focused history and physical exam can yield significant clinical clues and should prompt either inpatient or outpatient work-up.

In patients with deep ulcers and concern for critical limb ischemia, inpatient consultation should be sought. In patients with superficial venous or arterial ulcers, referral for outpatient ABI, color duplex ultrasound, or both should be made; most of these patients should also be directly referred to a vascular and/or wound specialist. Patients with more benign forms of disease who exhibit chronic symptoms suspicious for mild to moderate PAD or CVI can be seen by a PCP for further management. All patients should be educated about the importance of follow-up as it remains their best chance to curb the progression of disease, reduce the risks for recurrent infection, and improve overall quality of life.

Back to the original case

Our patient's lower extremity erythema, fever, and leukocytosis improved with 3 days of IV vancomycin treatment. Her wound was kept clean with moist dressings and showed no signs of deep infection; with elevation, her bilateral lower extremity edema also improved. Her physical exam findings and clinical history were highly suspicious for long-standing CVI. She was discharged with oral antibiotics and a referral to wound care for ongoing management of her superficial ulcers. An outpatient venous duplex ultrasound and ABI were scheduled prior to her vascular surgery appointment to effectively rule out PAD before consideration of further therapy for severe CVI. TH

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IN THE LITERATURE

ITL: Physician reviews of HM-related research

By Aparna Kamath, MD, MS; Suchita Shah Sata, MD; Noppon Setji, MD; Snehal Patel, MD; Adam Wachter, MD; and Faye Farber, MD

Duke University Health System, Durham, N.C.

IN THIS ISSUE

By Aparna Kamath, MD, MS

1 Idarucizumab reverses anticoagulation effects of dabigatran

CLINICAL QUESTION: Can idarucizumab reverse anticoagulation effects of dabigatran in a timely manner for urgent surgery or in the event of bleeding?

BACKGROUND: Reversing the anticoagulant properties of anticoagulants can be important in the event of a life-threatening bleed, or if patients taking these medications need urgent surgery or other interventions. Idarucizumab, a humanized monoclonal antibody fragment, can reverse anticoagulant activity of dabigatran, increasing its acceptance for prescribing physicians as well as patients.

Dr. Kamath

STUDY DESIGN: Multicenter prospective single cohort study.

SETTING: 173 sites, 39 countries.

SYNOPSIS: Among 503 patients (median age, 78 years, indication for dabigatran included stroke prophylaxis in setting of atrial fibrillation for most) who had either uncontrolled bleeding (n = 301) or needing emergent surgery (n = 202), a single 5-g dose of idarucizumab was able to reverse anticoagulation rapidly and completely in more than 98% of these patients independent of age, sex, renal function, and dabigatran concentration at baseline. Specifically in 68% of the patients in the bleeding group (excluding intracranial hemorrhage) median time to the cessation of bleeding was 2.5 hours and median time to the initiation of the procedure in the emergent surgery group was 1.6 hours. Study limited by lack of control group.

BOTTOM LINE: Idarucizumab can be effective for dabigatran reversal among patients who have uncontrolled bleeding or need to undergo urgent surgery.

CITATION: Pollack CV Jr. et al. Idarucizumab for dabigatran reversal: Full cohort analysis. N Engl J Med. 2017 Aug 3;377(5):431-41.

Dr. Kamath is a hospitalist and medical director of quality and patient safety, Duke Regional Hospital, Duke University Health System.

By Suchita Shah Sata, MD

2 You aren't (necessarily) a walking petri dish!

CLINICAL QUESTION: Does exposure to a patient with a multidrug-resistant organism result in colonization of a health care provider?

BACKGROUND: Multidrug-resistant organisms (MDROs) are growing threats in our hospitals, particularly vancomycin-resistant enterococci (VRE) and resistant gram-negative bacteria. The role of the health care team in preventing infection transmission is paramount. If a team member who is caring for a patient with an MDRO or handling lab specimens becomes colonized with these bacteria, he or she could potentially transmit them to the next patient.

STUDY DESIGN: Observational case control.

SETTING: Large academic research hospital.

SYNOPSIS: Staff submitted self-collected rectal swabs, which were then cultured for MDROs. 379 health care personnel (which they defined as having had self-reported exposure to MDROs) were compared with 376 staff members in the control group, who reported no exposure to MDROs. There was a nonsignificant difference between growth of multidrug-resistant organisms between the groups (4.0% vs 3.2%).

Dr. Sata

BOTTOM LINE: This study suggests that occupational exposure to an MDRO does not result in subsequent colonization of the health care provider and may not be a major risk factor for nosocomial transmission.

CITATION: Decker BK et al. Healthcare personnel intestinal colonization with multidrug-resistant organisms. Clin Microbiol Infect. 2017 May 12. pii:S1198-743X(17)30270-7.

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3 Treat sleep apnea with positive airway pressure, but don't expect it to prevent heart attacks

CLINICAL QUESTION: In patients with sleep apnea, does using positive airway pressure (PAP) treatment prevent adverse cardiovascular events and death?

BACKGROUND: Previous observational studies have suggested that untreated sleep apnea is a factor in cardiopulmonary morbidity as well as cerebrovascular events. Guidelines advise its use for prevention of cerebrovascular events. However, not enough is known from trials about its impact on prevention of cardiovascular events.

STUDY DESIGN: Systematic review with meta-analysis.

SYNOPSIS: The authors analyzed 10 randomized-controlled trials encompassing 7,266 patients with sleep apnea. They examined instances of major adverse cardiovascular events (MACE; acute coronary syndrome, stroke, cardiovascular death) as well as hospitalization for unstable angina and all-cause deaths, among others. They found no association between treatment with positive airway pressure and MACEs (169 events vs. 187 events, with a relative risk of 0.77; 95% confidence interval, 0.53-1.13) or all-cause death (324 events vs. 289 events, RR 1.13; 95% CI,0.99-1.29).

BOTTOM LINE: Positive airway pressure treatment for patients with sleep apnea is not an intervention to prevent cardiovascular morbidity.

CITATION: Yu J et al. Association of positive airway pressure with cardiovascular events and death in adults with sleep apnea. JAMA. 2017 Jul 11;318(2):156-66.

Dr. Sata is a medical instructor, Duke University Hospital.

By Noppon Setji, MD

4 Outcomes of alcohol septal ablation in younger patients with obstructive hypertrophic cardiomyopathy

CLINICAL QUESTION: Is alcohol septal ablation (ASA) safe in younger patients with obstructive hypertrophic cardiomyopathy (HCM)?

BACKGROUND: ASA is a class III recommendation for younger patients when myectomy is a viable option. This recommendation was based on the lack of evidence for younger patients whereas myectomy already was proven to be safe and effective.

STUDY DESIGN: International multicenter observational cohort design.

SETTING: 7 tertiary centers from 4 European countries during 1996-2015.

SYNOPSIS: With 1,200 patients, this was the largest ASA cohort to date. The cohort was divided into three groups: young (less than 50 years), middle age (51-65 years), and old (greater than 65 years). During the periprocedural period, young patients had better outcomes than did older patients in regards to complete heart block, cardiac tamponade, and mortality. After 5.4 years of follow-up, young patients had favorable outcomes for long-term survival after ASA and comparable rates of adverse antiarrhythmic events; 95% of these young patients were functioning in NYHA class I or II at follow-up. These young patients also had half the risk of permanent pacemaker implantation, compared with older patients. In an analysis of very young patients (younger than 35 years), ASA appeared to be safe and effective as well. Additionally, young patients who were treated with more than 2.5 mL alcohol had higher all-cause mortality, compared with patients who were treated with less than 2.5 mL.

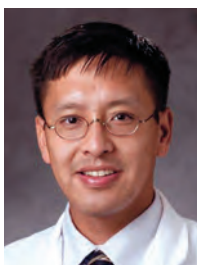
BOTTOM LINE: For patients aged 50 years or less with HCM, ASA and surgical myectomy are both safe and effective for relief of symptoms.

CITATION: Liebregts M et al. Outcomes of alcohol septal ablation in younger patients with obstructive hypertrophic cardiomyopathy. JACC: Cardiovascular Interventions. Jun 2017:1134-43.

5 Use of the dual-antiplatelet therapy score to guide treatment duration after percutaneous coronary intervention

CLINICAL QUESTION: Can the dual-antiplatelet therapy scoring system be used to determine which patients undergoing percutaneous coronary intervention (PCI) would benefit from prolonged (24 months) DAPT?

BACKGROUND: Prolonged DAPT therapy has been estimated to prevent 8 myocardial infarctions per 1,000 persons treated for 1 year but at the cost of 6 major bleeding events with no clear mortality benefit. Given these trade-offs, the DAPT score could be used to identify patients who would benefit or would be harmed from prolonged DAPT. The safety and efficacy of DAPT duration as guided by the DAPT score has not been assessed outside the derivation cohort. This study applied the DAPT score to the PRODIGY trial patients to evaluate safety and outcomes of DAPT for 24 months versus a less than 6-month regimen.


Dr. Setji

STUDY DESIGN: Retrospective use of the DAPT score in PRODIGY patients.

SETTING: PCI patients in PRODIGY trial.

SYNOPSIS: In the original derivation cohort, a low DAPT score of less than 2 identified patients whose bleeding risks outweigh ischemic benefits and a high score above 2 identifies patients for whom ischemic benefits outweigh bleeding risks. When the DAPT score was applied to the 1,970 patients enrolled in PRODIGY, 55% had a low score and 45% had a high score. The primary efficacy outcomes of death, MI, and stroke were evaluated as well as primary safety outcomes of bleeding according to the Bleeding Academic Research Consortium definition. The reduction in the primary efficacy outcomes with 24-month vs. 6-month DAPT was greater in patients with a high DAPT score but only in the older paclitaxel-eluting stents. Since these stents have mostly fallen out of favor, there are some limitations to the applicability of the study findings. The study also provides support for 6 months of DAPT for patients with a DAPT score of less than 2.

BOTTOM LINE: For patients who underwent PCI with a DAPT score of less than 2, the risk for bleeding appears to be higher than are the ischemic benefits, while patients who had a high DAPT score of greater than 2 with a first-generation stent, the ischemic benefits of prolonged DAPT seemed to outweigh the bleeding risks.

For patients who underwent PCI with a DAPT score of less than 2, the risk for bleeding appears to be higher than are the ischemic benefits, while patients who had a high DAPT score of greater than 2 with a first-generation stent, the ischemic benefits of prolonged DAPT seemed to outweigh the bleeding risks.

CITATION: Piccolo R et al. Use of the dual-antiplatelet therapy score to guide treatment duration after percutaneous coronary intervention. Ann Intern Med. 2017 Jul 4;167(1):17-25

Dr. Setji is a hospitalist and medical director, Duke University Hospital.

By Snehal Patel, MD

6 Urgent endoscopy is associated with lower mortality in high-risk patients with acute nonvariceal GI bleeding

CLINICAL QUESTION: Is urgent endoscopy (less than 6 hours after ED presentation) better than elective endoscopy (6-48 hours after presentation) to decrease mortality and rebleeding in high-risk patients with acute nonvariceal upper GI bleeding (ANVGIB)?

BACKGROUND: High-risk ANVGIB patients (Glasgow-Blatchford score greater than 7) are recommended to undergo early endoscopy, within 24 hours of presentation. The impact of urgent endoscopy (less than 6 hours) on patient outcomes is not clear.

STUDY DESIGN: Retrospective observation study.

SETTING: Single tertiary referral center in South Korea.

SYNOPSIS: Investigators retrospectively reviewed 961 high-risk ANVGIB patients, 571 patients underwent urgent endoscopy and 390 patients had elective endoscopy (6-48 hours), to compare clinical features and outcomes. The urgent group was slightly older, had a higher Rockall score, lower blood pressure, and higher incidence of shock on admission.


Dr. Patel

Urgent endoscopy was associated with significantly lower 28-day mortality (1.6% vs 3.8%). Urgent endoscopy also was associated with higher packed red blood cell transfusion volume (2.6 U vs. 2.3 U) and greater need for endoscopic intervention (69.5% vs. 53.5%) and embolization (2.8% vs. 0.5%). There was no significant difference in rebleeding rates, need for ICU admission, vasopressor use, and length of hospital stay between the urgent and elective endoscopy groups. The authors conclude that urgent endoscopy was associated with lower mortality rate but not rebleeding in high-risk patients with ANVGIB.

Despite differences between these two groups, based on these retrospective data, it is reasonable to suggest that urgent endoscopy may be beneficial for reducing mortality in high-risk patients with ANVGIB.

BOTTOM LINE: Urgent endoscopy may be beneficial in reducing mortality in high-risk patients with acute nonvariceal gastrointestinal bleeding.

CITATION: Cho SH et al. Outcomes and role of urgent endoscopy in high-risk patients with acute nonvariceal gastrointestinal bleeding. Clin Gastroenterol Hepatol. 2017 Jun 19. pii: S1542-3565(17)30736-X.

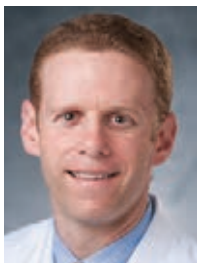
Dr. Patel is a hospitalist and an assistant professor of medicine, Duke University Health System.

By Adam Wachter, MD

7 Isolation precautions are associated with higher costs, longer LOS

CLINICAL QUESTION: What are the effects of isolation precautions on hospital outcomes and cost of care?

BACKGROUND: Previous studies have found that isolation precautions negatively affect various aspects of patient care, including frequency of contact with clinicians, adverse events in the hospital, measures of patient well-being, and patient experience scores. It is not known how isolation precautions affect other hospital-based metrics, such as 30-day readmissions, length of stay (LOS), in-hospital mortality, and cost of care.


Dr. Wachter

STUDY DESIGN: Multisite, retrospective, propensity score–matched cohort study.

SETTING: Three academic tertiary care hospitals in Toronto.

SYNOPSIS: The authors used administrative databases and propensity-score modeling to match isolated patients and nonisolated controls. Researchers included 17,649 control patients, 737 patients isolated for methicillin-resistant *Staphylococcus aureus* (contact isolation), and 1,502 patients isolated for respiratory illnesses (contact and droplet isolation) in the study. Patients isolated for MRSA had a higher 30-day readmission rate than did controls (19% vs. 14.7%),

PEDIATRIC HM LITERATURE | By Sam Stubblefield, MD

Dr. Stubblefield is a pediatric hospitalist at Nemours/Alfred I. duPont Hospital for Children in Wilmington, Del., and a clinical assistant professor of pediatrics at Jefferson Medical College in Philadelphia.

Pediatric acute appendicitis: Is it time for nonoperative treatment (NOT)?

CLINICAL QUESTION: What are the differences in rates of treatment failure, duration of hospitalization, and cost between nonoperative treatment (NOT) for acute uncomplicated appendicitis versus urgent appendectomy?

BACKGROUND: Acute appendicitis is found in around 5% of children presenting for urgent or emergent evaluation of abdominal pain. It is the most common illness prompting emergency abdominal surgery in children.

Possible complications from appendicitis include perforation, gangrenous changes, peritonitis, and sepsis. To avoid these significant morbidities, surgical teaching for more than a century has recommended urgent removal of the appendix in acute uncomplicated appendicitis. Appendicitis is classified as "complicated" if there is evidence of perforation, abscess, or gangrenous changes, and "uncomplicated" otherwise.

Several trials in adults have shown that urgent surgery may not be necessary, and NOT of uncomplicated appendicitis may be both effective and safe. NOT involves a course of IV antibiotics and careful clinical monitoring while hospitalized, then a course of oral antibiotics after discharge. Regimens vary but include coverage for aerobic and anaerobic gut flora, such as piperacillin-tazobactam followed by amoxicillin. Little is known about the safety and efficacy of NOT in children.

STUDY DESIGN: Meta-analysis.

SEARCH STRATEGY: PubMed, MEDLINE, EMBASE, and Cochrane Library were searched for relevant studies. This search identified 527 potential articles, of which the authors examined the full text of 68 and ultimately identified 5 single-center trials for analysis (4 prospective cohort trials and 1 randomized, controlled trial).

SYNOPSIS: A total of 404 patients with uncomplicated appendicitis were seen in all trials: 168 received NOT and 236 received standard surgical care (urgent appendectomy). In the single randomized, controlled trial, patients were assigned NOT or surgical care randomly. In the other trials parental preference directed therapy.

The heterogeneity of the design, populations, definitions of illness, duration of follow-up, and NOT treatment regimens made the meta-analysis challenging. Antibiotic options for NOT varied by center but included a course of IV antibiotics followed by 7-10 days of oral antibiotics. NOT success was defined as no need for surgery within 48 hours and no recurrence of appendicitis within 1 month. Of the 236 patients who received standard surgical care, all had appendicitis and 1 had a complication requiring repeat operation. Of the NOT group, 16 (9.5%) had treatment failures, including 3 with perforated appendicitis, and 45 (27%) went on to have an appendectomy within the following year, yielding a risk ratio of failure versus standard treatment of 8.9 (95% confidence interval, 2.7-29.8). A subgroup analysis of patients with appendicoliths who received NOT found that these patients experienced a substantially increased risk of treatment failures and recurrent appendicitis with the risk ratio versus NOT without appendicolith of 10.4 (95% CI, 1.5-74). Of the 30 patients who experienced treatment failure with NOT, 15 had appendicoliths. NOT lengthened hospital stays by 14.3 hours (95% CI, 7.5-21.1) but led to lower total costs by $1,310 (95% CI, $920-$1,690).

BOTTOM LINE: NOT may be a reasonable alternative to standard surgical management for acute uncomplicated appendicitis without appendicolith in children, with a success rate of greater than 90%.

Further larger, randomized prospective studies are required to establish its safety and efficacy.

CITATION: Huang L et al. Comparison of antibiotic therapy and appendectomy for acute uncomplicated appendicitis in children: A meta-analysis. JAMA Pediatr. 2017;171(5):426-34.

a longer average length of stay (11.9 days vs. 9.1 days), and higher direct costs ($11,009 vs. $7,670). Patients isolated for respiratory illnesses had a longer average length of stay (8.5 days vs. 7.6 days) and higher direct costs ($7,194 vs. $6,294). No differences in adverse events rates or in-hospital mortality were observed between control patients and patients in either isolation group.

Some of the differences observed may be from illness severity rather than from the effects of isolation, especially in the MRSA group. There was no difference observed in rates of adverse outcomes, such as falls or medication errors, or in rates of formal patient complaints to the hospital. It is possible that propensity score modeling corrected for unidentified biases in prior studies that found differences in these types of outcomes.

BOTTOM LINE: Isolation precautions are associated with higher costs and longer LOS in hospitalized general medicine patients.

CITATION: Tran K et al. The effect of hospital isolation precautions on patient outcomes and cost of care: A multisite, retrospective, propensity score-matched cohort study. J Gen Intern Med. 2017;32(3):262-8.

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8 Text paging practices need improvement, standardization

CLINICAL QUESTION: What is the content and structure of patient care–related text paging sent in the inpatient setting?

BACKGROUND: Text paging has become a common form of communication among members of the inpatient multidisciplinary team, but there are potential risks and downsides of text paging, including disruptiveness, inefficiency, and potential patient safety issues.

STUDY DESIGN: Modified case-study approach.

SETTING: The medical inpatient service of an academic tertiary care hospital.

SYNOPSIS: 575 text-page messages relating to 217 unique patients were analyzed in the study. The majority of the messages were sent from nonphysicians to physicians. Common themes that were identified included lack of standardization of text-message content and format, lack of indicators of the urgency of the message, and lack of clarity within the message. Pertinent information sometimes was missing from the messages, and it was not always clear whether the sender was requesting a response from the recipient.

BOTTOM LINE: Text-paging practices may raise patient safety issues that could be addressed by implementation of a standardized, structured approach to this form of communication.

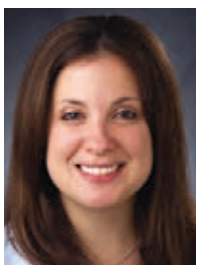
CITATION: Luxenberg A et al. Efficiency and interpretability of text paging communication for medical inpatients: A mixed-methods analysis. JAMA Intern Med. 2017;177(8):1218-20.

Dr. Wachter is an assistant professor of medicine at Duke University.

By Faye Farber, MD

9 Addition of azithromycin to maintenance therapy is beneficial in adults with uncontrolled asthma

CLINICAL QUESTION: Does azithromycin decrease the frequency of asthma exacerbations in adults with persistent asthma symptoms despite use of inhaled corticosteroid (ICS) and a long-acting beta-agonist (LABA)?



Dr. Farber

BACKGROUND: Asthma is a chronic inflammatory airway disease that is highly prevalent worldwide within a subset of people with asthma who have symptoms that are poorly controlled despite ICS and LABA maintenance therapy. Currently, add-on therapy options include monoclonal antibodies, which are cost prohibitive. The need for additional therapeutic options exists. At the same time, macrolide antibiotics are known to have anti-inflammatory, antiviral, and antibacterial effects and have proven to have beneficial effects on asthma symptoms.

STUDY DESIGN: Randomized, double-blind, placebo-controlled trial.

SETTING: Multiple sites throughout Australia.

SYNOPSIS: The AMAZES trial enrolled 420 adult patients with symptomatic asthma despite current use of ICS and LABA. Patients were randomly assigned to receive azithromycin 500 mg or placebo three times a week for 48 weeks. Patients who had hearing impairment, prolonged QTc interval, or emphysema were excluded.

Azithromycin reduced the frequency of asthma exacerbations, compared with placebo (1.07 vs. 1.86 exacerbations/patient-year; incidence rate ratio 0.59; 95% confidence interval, 0.47-0.74; *P* less than .0001). It also significantly improved asthma-related quality of life according to the Asthma Quality of Life Questionnaire (adjusted mean difference, 0.36; 95% CI, 0.21-0.52; *P* = .001). Diarrhea occurred more commonly in the azithromycin group but did not result in a higher withdrawal rate.

A significant limitation of this study was generalizability, as the median patient age was 60 years and race was not reported. More research is needed to determine the effect of long-term azithromycin use on microbial resistance.

BOTTOM LINE: Adding azithromycin to maintenance ICS and LABA therapy in patients with symptomatic asthma decreased the frequency of asthma exacerbations and improved quality of life.

CITATION: Gibson PG et al. Effect of azithromycin on asthma exacerbations and quality of life in adults with persistent uncontrolled asthma (AMAZES): A randomised, double-blind, placebo-controlled trial. Lancet. 2017 Aug 12;390(10095):659-68.

10 Improvements made in safe opioid prescribing practices but crisis far from over

CLINICAL QUESTION: How have national and county-level opioid prescribing practices changed from the years 2006 to 2015?

BACKGROUND: The opioid epidemic is currently at the forefront of public health crises, with more than 15,000 deaths caused by prescription opioid overdoses in 2015 alone and an estimated 2 million people with an opioid use disorder associated with prescription opioids. The opioid epidemic also has a significant financial burden with the cost of opioid overdose, abuse, and dependence totaling $78.5 billion/year in the United States. As the utilization of opioids to treat noncancer pain quadrupled during 1999-2010, so did the prevalence of opioid misuse disorder and overdose deaths from prescription opioids. This study reviewed prescribing practices at the national and county level during 2006-2015 in hopes of understanding how this affected the opioid crisis.

STUDY DESIGN: Review of opioid prescription data.

SETTING: The data were summarized from a sample of pharmacies throughout the United States.

SYNOPSIS: Data were obtained via the QuintilesIMS Data Warehouse, which estimated the number of opioid prescriptions, based upon a sample of 59,000 U.S. pharmacies (88% of total prescriptions). The amount of prescriptions peaked in 2010 then decreased yearly through 2015, yet remained about three times as high as prescription rates from 1999. Opioid prescribing practices had significant variation throughout the country, with higher prescription rates associated with smaller cities, larger white population, higher rates of Medicaid and unemployment, and higher prevalence of arthritis and diabetes. Variation in prescribing practices at the county level represents lack of consensus and evidence-based guidelines.

The authors suggest that providers carefully weigh the risks and benefits of opioids and review the Guideline for Prescribing Opioids for Chronic Pain from the Centers for Disease Control and Prevention. At the state and local levels, mandated pain clinic regulations and Physician Drug Monitoring Programs also are needed for continued improvement in opioid-related deaths. Weaknesses of study included lack of clinical outcomes and use of QuintilesIMS to estimate prescriptions that has not been validated.

BOTTOM LINE: Although rates of opioid prescriptions have improved since 2010, substantial changes and regulations for prescribing practices are needed at the state and local levels.

CITATION: Guy GP Jr. et al. Vital Signs: Changes in opioid prescribing in the United States, 2006-2015. MMWR Morb Mortal Wkly Rep. 2017;66:697704.

Dr. Farber is a medical instructor, Duke University Health System. TH

SHORT TAKES

Early furosemide treatment associated with decrease in hospital mortality for acute heart failure

This prospective multicenter observational trial showed that if intravenous furosemide was administered to patients with acute heart failure who had prominent congestive symptoms within 60 minutes of their arrival to the emergency department, it was associated with a decrease in hospital mortality (odds ratio, 0.42; 95% confidence interval, 0.24-0.72; *P* less than.001) even after the researchers adjusted for Get With The Guidelines heart failure risk scores.

CITATION: Matsue Y et al. Time-to-furosemide treatment and mortality in patients hospitalized with acute heart failure. J Am Coll Cardiol. 2017 Jun 27;69(25):3042-51.

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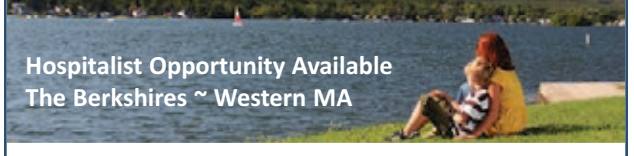

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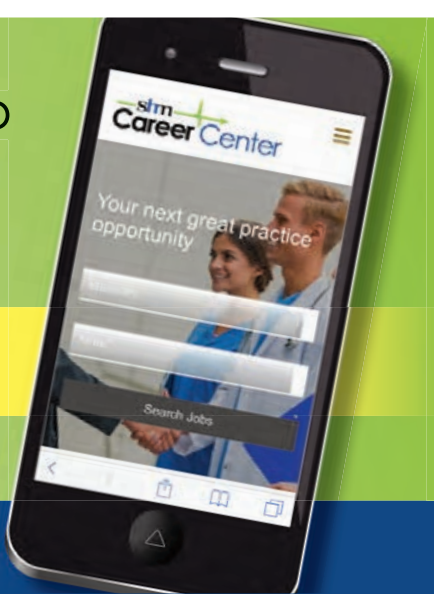

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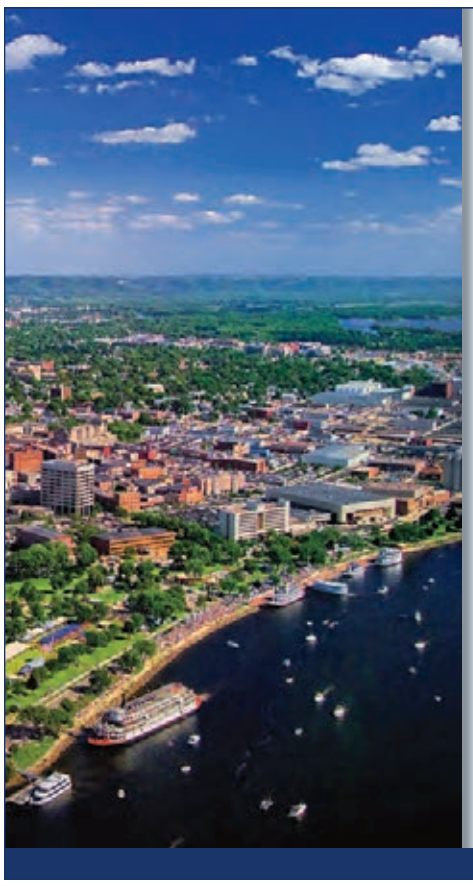
Contact Information:
Lauren Simon, Administrative Supervisor, 856-342-3150
Simon-Lauren@cooperhealth.edu **www.cooperhealth.org**



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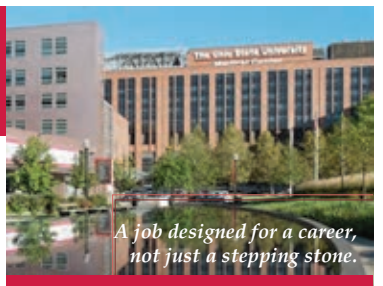

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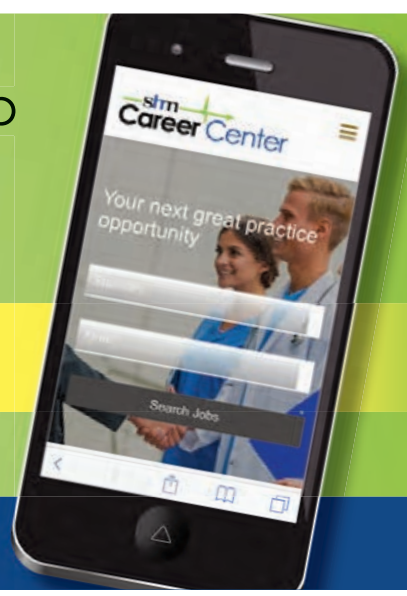

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DACA: Time to act

Path to citizenship for 'Dreamers' would be welcomed by most Americans

Dr. Scheurer is a hospitalist and chief quality officer at the Medical University of South Carolina in Charleston. She is physician editor of The Hospitalist. Email her at scheured@musc.edu.

President Trump recently announced his decision to officially end the Deferred Action for Childhood Arrivals program, also known as DACA. The program has been controversial since its inception, almost as controversial as the decision to end it. What impact has DACA had on the medical community, including hospitalists, and what are the implications of ending it?

DACA is a program started in 2012 by an executive action under the Obama administration. The program currently protects approximately 800,000 undocumented immigrants in the United States from being deported. All DACA recipients were brought to this country illegally as children. When the DACA program began, in order to enroll, recipients had to prove that they had arrived here before age 16, and that they had been living in the United States continuously since 2007. Once enrolled, the protections they receive from the program include the ability to legally work and to go to school, as well as obtain a social security number and driver's license. These protections are then afforded for renewable 2-year periods of time.[1]

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DACA recipients are also known as "Dreamers," as DACA was created by the Obama administration after Congress did not pass the Development, Relief, and Education for Alien Minors (DREAM) act. If the DREAM act had passed, it would have offered these same DACA recipients the opportunity to potentially gain permanent legal residency. Although attempted many times, neither the DREAM Act nor any other legislation like it has garnered enough support to be passed by Congress.

When Mr. Trump was elected, the controversy over continuing the DACA program accelerated. Understandably, the volume of applications rose substantially, with some estimating 8,000 renewal requests being filed each week since the election. As such, many estimate the number of illegal immigrants affected by DACA has reached almost 1 million.[1]

One of the reasons the Trump administration feels compelled to dismantle the program is they contend that DACA is unconstitutional, as it was established purely by executive order. In the meantime, Mr. Trump is urging Congress to replace DACA with some type of equivalent legislation. According to his staffers, the dismantling of DACA means:

- No new applications will be accepted.
- All existing permits will be honored until they expire.
- All applications in process will continue to be processed.

They contend that no current DACA recipients will be affected before March 2018. Unfortunately for the Trump administration, this has been a very unpopular move, as two-thirds of Americans support allowing the Dreamers to stay in the United States.[1]

Impact on health care

The concern for the medical industry is that a "dismantling" of DACA could exacerbate an already existing physician shortage in the United States. For example, the Association of American Medical Colleges estimates the physician shortage will rise as the population ages and medical access increases; they currently estimate a physician shortage of approximately 40,000-104,000 by 2030.

Along similar lines, the American Medical Association wrote in a letter to congressional leaders: "We particularly are concerned that this reversal in policy could have severe consequences for many in the health care workforce, impacting patients and our nation's health care system. … Our nation's health care workforce depends on the care provided by international medical graduates – one out of every four physicians practicing in the United States is an IMG. These individuals include many with DACA status who are filling gaps in care."[2]

But objectively evaluating the impact of the DACA program on the medical industry is difficult. We do know that most of the DACA recipients arrived from Mexico, El Salvador, Guatemala, and Honduras, as well as from Asia (primarily South Korea and the Philippines). We also know they reside in every state, with the largest numbers in California (222,795), Texas (124,300), New York (41,970), Illinois (42,376), and Florida (32,795). Most appear to be using DACA to work and to go to school; in a recent survey, 91% were employed, and 45% were enrolled in school.[1]

Pertaining specifically to medical school, during the 2016-2017 school year, there were 113 DACA applicants to U.S. medical schools, 65 of which were accepted and enrolled. The AAMC expects the 2017-2018 enrollment to be even higher. Almost half of medical school enrollees attend Loyola University Chicago, Maywood, Ill.; this year alone, Loyola Stritch Medical School enrolled 32 DACA medical students. This is because, in 2013, Loyola was the first medical school nationwide to openly accept students with DACA status. They did this by creating a mechanism for DACA medical students to get student loans.

One of the biggest challenges for DACA students is paying for school, as they are not eligible for federal student loans. To remove this barrier, Loyola created a loan program through the Illinois Finance Authority, which offers interest-free loans to DACA students if they commit to paying back the principal and working after medical school for 4 years in an underserved area in Illinois. It is clear that no medical school in the country will feel the effects of the DACA dismantling more than will Loyola.[3]

Another unintended issue that the dismantling of DACA can have on the medical industry is the temptation for undocumented immigrants to avoid seeking medical care, for fear of being discovered and deported. Such delays in seeking care can result in these patients presenting with significant and expensive medical issues.

So what are the options for Congress and what is the likely fate of these DACA recipients whose lives have been placed in limbo? Proposals introduced to date include:

- The Bridge Act, which effectively extends the present DACA program by 3 years.
- Recognizing America's Children Act, which would allow people who meet DACA eligibility criteria to apply for conditional permanent residence with a path toward citizenship.
- The American Hope Act and updated DREAM Act, both of which propose broader eligibility criteria and faster pathways to citizenship.[4]

There is great hope that some definitive action can be employed by Congress, as most legislators on both sides of the aisle have expressed some support for at least one of the proposed policies (although that certainly does not guarantee sufficient votes to pass). There also is support from many Americans, given that most DACA recipients have been productive members of society, and most Americans believe that DACA recipients should not be held accountable "for the sins of their parents."[4]

It appears that the dismantling of DACA would be quite unsettling and certainly would affect some areas of the country more severely than others. Regardless of political stance, everyone can agree that Congress needs to do something, as the ambiguity and uncertainty caused by a million undocumented immigrants living and working in the United States cannot be ignored or indefinitely deferred. Any of the above options that offer a pathway to citizenship would be welcomed by most Americans. Having Dreamers in limbo is bad for everyone; the time to act is now. TH

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